MARKET CONDUCT EXAMINATION REPORT
Dated February 24, 2012

COVERING THE TIME PERIOD OF JANUARY 1, 2009 THROUGH DECEMBER 31, 2009

UNITED AMERICAN INSURANCE COMPANY

3700 South Stonebridge Drive
McKinney, TX 75070-8080

NAIC Company Code: 92916
NAIC Group Code: 290

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

UNITED AMERICAN INSURANCE COMPANY
3700 South Stonebridge Drive
McKinney, TX 75070-8080

MARKET CONDUCT EXAMINATION REPORT DATED FEBRUARY 24. 2012

Covering the Time Period of January 1, 2009 through December 31, 2009

Examination Performed by:

State Market Conduct Examiners

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Examiner-In-Charge

And

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COMPANY PROFILE

The following profile is based on information provided by United American Insurance Company and has not been verified by the Colorado Division of Insurance:

United American Insurance Company was organized on June 13, 1947, as a limited capital stock insurance company offering life, health, and accident insurance. Originally United American was incorporated in the State of Texas. It was redomiciled to the State of Delaware in 1982, and to the State of Nebraska as of December 12, 2007.

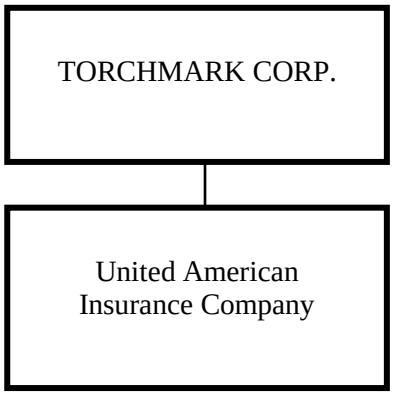
The Company commenced business on August 13, 1947. A license to transact business in the State of Colorado as a life insurance company was granted to the Company on December 11, 1981. The Colorado license authorized United American to conduct accident, health, and general life business.

Globe Life And Accident Insurance Company, a wholly owned subsidiary of Torchmark, purchased all of the outstanding common stock of United American, on December 31, 1981. Torchmark acquired United American as a direct subsidiary, on December 31, 1981.

The Company is licensed to transact business in all states, except New York. The Company is also licensed in the District of Columbia and Canada. United American primarily markets life and health insurance products to seniors, which includes guaranteed renewable Medicare supplement and long-term care insurance.

STRUCTURE AS OF DECEMBER 31, 2009

An abbreviated organizational chart depicting United American's relationship with its ultimate controlling entity as of December 31, 2009 is depicted below:



Premium and Market Share as of December 31, 2009:

Total Written Premium:	$ 9,276,000*
Group and Individual A&H Written Premium	$ 8,852,064**
Market Share (As a percentage of Colorado Total Accident and Health):	0.08%*

- * As shown in the 2009 Edition of the Colorado Insurance Industry Statistical Report
- ** As reported by the Company

PURPOSE AND SCOPE

A state market conduct examiner with the Colorado Division of Insurance ("Division"), who was assisted by independent contract examiners, reviewed certain business practices of United American Insurance Company ("United" or "Company"). The market conduct examination ("MCE") was performed in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205 and 10-3-1106, C.R.S., that empower the Commissioner of Insurance ("Commissioner") to examine any entity engaged in the business of insurance in the State of Colorado. All work product developed in producing this report is the sole property of the Division.

The purpose of the examination was to determine the United's compliance with Colorado insurance laws related to health insurance written in Colorado. Examination information contained in this report should serve only this purpose, except as provided in law pursuant to §§ 10-1-204 and 10-1-205, C.R.S. The findings and conclusions, including the Final Agency Order, arising out of this examination shall be a public record.

Examiners conducted the examination in accordance with procedures developed by the Division which are based on model procedures developed by the National Association of Insurance Commissioners ("NAIC"). They relied primarily on records and materials maintained and/or supplied by the United. This MCE covered the period from January 1, 2009, through December 31, 2009.

The examination included review of the following:

Company Operations and Management
Contract Forms
Rates
Claims

The examination report is a report by exception. References to additional practices, procedures, or files that did not exceed the error tolerance levels established by the NAIC were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits United to submit written responses to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to individual and large group health insurance laws. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific United practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the laws and regulations as shown below.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration.
Section 10-3-903, C.R.S.	Definition of transacting insurance business.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age – coverage for students who take medical leave of absence.
Section 10-16-104.7, C.R.S.	Substance abuse – court-ordered treatment coverage.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal.
Section 10-16-106.3, C.R.S.	Uniform claims – billing codes – electronic claim forms.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain.
Section 10-16-107.2, C.R.S.	Filing of health policies.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – internal review – rules.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-135, C.R.S.	Health benefit plan information cards – rules – standardization – contents.
Section 10-16-201, C.R.S.	Form and content of individual sickness and accident insurance policies.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modification of health benefit plans.
Section 10-16-202, C.R.S.	Required provisions in individual sickness and accident policies.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-18-101, C.R.S.	Definitions.
Insurance Regulation 1-1-6	Concerning The Elements Of Certification For Accident and Health Forms
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy" For Use In Accident And Health Insurance Policies
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access To Obstetricians, Gynecologists And Certified Nurse

	Midwives Under Managed Care Plans
Insurance Regulation 4-2-18	Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions
Insurance Regulation 4-2-20	Concerning the Colorado Health Benefit Plan Description Form
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements For Health Carriers
Insurance Regulation 4-2-27	Procedures For Reasonable Modifications To Individual And Small Group Health Benefit Plans
Insurance Regulation 4-2-29	Concerning the Rules for Standardized Cards Issued to Persons Covered by Health Benefit Plans
Insurance Regulation 4-2-30	Concerning The Rules For Complying With Mandated Coverage Of Hearing Aids And Prosthetics
Emergency Regulation 08-E-12 (effective 1/1/09)	Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-5	Concerning Small Employer Group Health Benefit Plans And The Basic And Standard Health Benefit Plans
Insurance Regulation 4-6-9	Conversion Coverage

Sampling Methodology

The examiners selected all files where a sample of a larger population was taken, on a random sample basis in accordance with the sampling methodology and sample sizes set forth in the 2010 NAIC Market Regulation Handbook ("Handbook").

Where the error rates of the samples indicated it would be appropriate to select an additional sample per the sampling instructions in the Handbook, but the initial results were conclusive, United was afforded the opportunity to agree that the initial sample was appropriate or request an additional sample be selected. In each such case, United indicated that the initial sample was appropriate.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, or ten percent (10%) for other samples, was established per the Handbook to determine reportable exceptions.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved in the accuracy of processing claims. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, administrative, underwriting and claims guidelines/procedures, and timely cooperation with the examination process.

Contract Forms

The examiners reviewed the following forms:

INDIVIDUAL HEALTH POLICIES

Form Number	Form Name
GSP3A	Limited Benefit Surgical Medical Expense Policy As of 09/01/10 Company stopped marketing this plan in Colorado
GSP3	Limited Benefit Surgical Medical Expense Policy As of 09/01/10 Company stopped marketing this plan in Colorado
SA(05) U1318(05)	Supplemental Application; Replacement Form
MMGAP, DS-MMGAP	Limited Benefit Surgical Expense Policy; Outline
CANLS-2	Cancer Policy
GSP2, DS-GSP2	Health Policy and Outline of Coverage As of 09/01/10 Company stopped marketing this plan in Colorado
CILS, DS-CILS	Policy-Outline of Coverage-Critical Illness
GSP1, DS-GSP1A & B	Hospital Policy, Outlines of Coverage As of 09/01/10 Company stopped marketing this plan in Colorado
CS1, DS-CS1 (05)	Basic Hospital Expense Policy, Outline of Coverage As of 09/01/10 Company stopped marketing this plan in Colorado
CAGR	Good Risk Cancer Policy
SHXC & DS-SHXC	Hospital and Surgical Expense Policy and Outline of Coverage As of 09/01/10 Company stopped marketing this plan in Colorado
HSXC-C	Hospital Surgical Expense Policy As of 09/01/10 Company stopped marketing this plan in Colorado
SMXC	Surgical and Medical Expense Policy As of 09/01/10 Company stopped marketing this plan in Colorado
CAXC	Cancer Expense Policy
CIXC	Cancer Indemnity Policy
HMXC	Hospital Indemnity Policy As of 09/01/10 Company stopped marketing this plan in Colorado
MMXC	Hospital and Surgical Expense Policy
HIXC	Hospital Indemnity Policy
SSXC-C	Surgical Expense Policy As of 09/01/10 Company stopped marketing this plan in Colorado

MSXC	Medical-Surgical Expense Policy

As of 09/01/10 Company stopped marketing this plan in Colorado

RIDERS

Form Number	Form Name
R-MMGAP-HO	Hospital Outpatient Rider
R-CIX	Critical Illness Rider
R-CANR	Cancer Rider
R-CILS2	Critical Illness Rider
R-ACC2	Accident Rider
NMHPA	Newborns' & Mothers Health Protection Rider
BR151RS	Prosthetic Device & Reconstructive Surgery Rider
EBRG, BRO51AN, BRO91DC	Various Riders (1) Exclusionary Rider for High Blood Pressure, (2) Coverage For Hospitalization & General Anesthesia for Dental Procedures for Dependent Children (3) Diabetes Coverage
SBRG, BR051M, BR051P	Various Riders (1) Select Benefit Rider-Modification of Benefits for diabetes, (2) Benefits for Mammography, (3) Additional Definitions, Prostate Cancer Screening
R-Colo(9S)	Rider-Cancer Expense Policy-Definition of Hospital
R-COP (5)	Definition of Complications of Pregnancy
R-NBC (1)	Newborn Children's Provision
R-Colo. (5) 3-77	Definition of Hospital
R-0CP 7/79	Ownership; Control of Policy
R-DOPR	Term of Physician-Does not include a Family Member
APVB	Additional Physician Visits Benefit
UA-250	Accident Expense Policy

APPLICATIONS

Form Number	Form Name
UNIV(05), UNIV)05)-ODF	Health Application & Optional Dependents Form

MGAPB, MGAPB-ODF	Health Application & Optional Dependents Form
DS-GSP-2R	Health Policy Outline of Coverage Revision
LCGP (05), LCGP(05)-ODF	Health Application & Optional Dependents Form
CILS-APR(05)	Application for Policy CILS
GSP-AP	Application for Policy GSP1
UC-AP 5/91	Health Application
HA-7(05)	Application for Basic Hosp Expense Policy
CA-2	Good Risk Cancer Policy Application
HA-1	Application for Hospital Surgical Expense Policy
MA4	Application used with various A&H Policies
CA-1	Application for Cancer Policy Plans
UCS-AP	Application for Surgical Medical Expense Policy
SA05	Supplement to Accident & Sickness Insurance Application
U1318 (05)	Notice Regarding Replacement of Accident & Sickness Insurance (Revision as of 10/07)

DISCLOSURE STATEMENTS

Form Number	Form Name
MSNOT06-1, 2, 5, 8	Health Disclosure Statements (Medicare Beneficiaries)

LARGE GROUP HEALTH CERTIFICATES

Form Number	Form Name
GRGSP2C	Certificate Form for Group Insurance Policy GRGSP2 Limited Hospital and Surgical Expense Group Product
TRHPC	Teamsters Retiree Health Plan Certificate
ERHPC-CO	Employer Retirement Health Plan Certificate

RIDERS

BRO81CP	Child Preventive and Primary Care Services

BR081M	Mammography Benefits
BRO81PP	Cervical Cytologic Screening Coverage
BRO81PC	Prostate Cancer Screening Benefit
BRO81DC	Diabetes Coverage
BRO81RC	Colorectal Cancer Screening Benefit
BR151RS	Prosthetic Device and Reconstructive Surgery Benefit
BRO82SA	Substance Abuse and Mental Illness Coverage
EBGR	Exclusionary Rider

APPLICATIONS

Form Number	Form Name
GRHAP	Application for Policy GRGSP2

Rates

Rate filings for large group retiree health benefit plans being marketed in Colorado during the period under examination were requested. The Company was unable to provide the requested rate filings.

Claims

The Company uses Competitive Health, PHCS and Careington for repricing of claims. Through these repricers the Company can access discounts through various other companies including PPONext, Three Rivers, Beech Street, Provider Select, First Access and Multiplan. Policies eligible for repricing discounts are identified by either their agreement to participate in the network of providers or by them paying an additional fee to join this network. The discounts are passed on to insureds and even services that are not covered by the insured's particular plan are sent for repricing if applicable in order to achieve savings for the insured.

Per information provided by the Company, with the exception of one type policy (GSP3), the amount paid for mammogram screenings is up to the outpatient benefit limit of the policy. If a claim presents with a mammography CPT code, the claim pends for examiner review to determine whether it should be paid as outpatient or as a screening mammogram, with the better benefit being paid. For GSP3 plans in Colorado, CPT codes convert to the mammogram benefit code. The formula for mammogram benefit codes pends the claim after calculation for the examiner to confirm amounts. The Company updates the Colorado mammography benefit every year to reflect increases and decreases in the Consumer Price Index on September 1st, and the update is provided to the GSP3 plan supervisor and claim examiners.

The claims reviewed during this exam had been processed by claims examiners located in Oklahoma City, Oklahoma.

The Company indicated that the only claims received electronically were Medicare Supplement claims and no Medicare Supplement claims were included in the scope of this examination. As a result the two (2) categories of claims reviewed for timeliness of processing were those exceeding forty-five (45) days and those exceeding ninety (90) days to process. The following random samples were produced using ACL "TM" software for review of overall claim handling and accuracy of payment.

- One hundred eight paid claims from a population of 4,862 claims received during the examination period.

- One hundred eight denied claims from a population of 4,465 claims received during the examination period.

From a population of 9,327 paid and denied claims received during the examination period, the following were identified and reviewed:

- Eighty-nine (89) paid and denied non-electronically received claims that exceeded forty-five (45) days to process.

- Twenty-two (22) paid and denied claims that exceeded ninety (90) days to process.

Utilization Review

In response to the request for utilization review procedures, decisions made involving utilization review, provider manuals and contracts that address utilization review, and copies of utilization review committee minutes, the Company responded in part:

> United American does not engage in processes that meet the definition of utilization review as defined by Colorado law. That is, the Company does not conduct or obtain ambulatory reviews, prospective reviews, second opinions, certifications, concurrent reviews, case management, discharge planning, or retrospective review. Nor does the Company perform reviews of treatment to determine whether same is considered experimental or investigational in a given circumstance, or reviews of an insured's medical circumstances when necessary to determine if an exclusion applies in a given situation.
>
> The Company does not issue any major medical or comprehensive health insurance coverage. Rather, United American's health products are supplemental in nature, and are primarily comprised of Medicare supplement, limited benefit hospital/medical/surgical coverage, and hospital indemnity policies. These products' benefit structures are such that utilization review is not necessary in order to adjudicate claims made under such products.

Prior Examinations

United's most recent market conduct examination by the Division prior to this examination was completed in 2004 and was focused on Medicare Supplement insurance business covering an exam period of July 1, 2003 through June 30, 2004.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirty-five (35) findings in which the Company was not compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

Company Operations and Management: The examiners identified two (2) areas of concern in their review of the Company's Operations and Management.

Issue A1: Failure to file the Annual Report of Certification of Forms.

Issue A2: Failure to automatically issue Certificates of Creditable Coverage.

Contract Forms: The examiners identified thirty (30) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

Issue E1: Failure to reflect a correct or complete description of the mandated benefits for mammography screening.

Issue E2: Failure to reflect a complete, or in some instances, any description of the required coverage to be provided for annual prostate cancer screenings.

Issue E3: Failure, in some instances, to reflect the correct provisions under which coverage is to be provided for newborn dependents or a child placed for adoption.

Issue E4: Failure to allow reimbursement for covered services when lawfully performed by a licensed provider that is a family member or who resides in the insured's household.

Issue E5: Failure, in some instances, to allow coverage for hospitalization and general anesthesia for dental procedures for qualified dependent children.

Issue E6: Failure, in some instances, to reflect the mandated benefit for cervical cancer vaccination for all females for whom a vaccination is recommended.

Issue E7: Failure to reflect correct benefits, or in some instances, any benefits for child health supervision services.

Issue E8: Failure, in some instances, to reflect correct or complete benefits for home health services and hospice care coverage.

Issue E9: Failure, in some instances, to reflect the mandated benefit coverage for prosthetic devices.

Issue E10: Failure, in some instances, to reflect the mandated coverage for early intervention services for an eligible child.

Issue E11: Failure, in some instances, to reflect the mandated coverage of hearing aids for minor children who have a hearing loss or reflecting an exclusion for hearing aids.

Issue E12: **Failure, in some instances, to reflect correct or complete required therapy visits for congenital defects and birth abnormalities.**

Issue E13: **Failure, in some instances, to reflect any or a complete description of the mandated minimum coverage to be provided for maternity and newborn hospital stays.**

Issue E14: **Failure, in some instances, to allow benefits for any loss incurred while an insured is engaged in the military, naval or air services of any country.**

Issue E15: **Failure, in some instances, to reflect the required definition of complications of pregnancy or to reflect that this is a mandated coverage to be provided for as any other similar sickness or disease is otherwise covered under the policy or certificate of insurance.**

Issue E16: **Failure, in some instances, to define correctly or completely the requirements for a person to qualify as a dependent.**

Issue E17: **Failure, in some instances, to reflect any information about the effect creditable coverage would have on any preexisting period.**

Issue E18: **Failure, in some instances, to reflect correct benefits or to reflect any benefits for treatment and services to be provided to newborn children born with cleft lip or cleft palate.**

Issue E19: **Failure, in some instances, to reflect correct and complete required provisions in individual and group policies.**

Issue E20: **Failure, in some instances, to reflect correctly or to reflect any benefits to be paid for the preventive health care service of colorectal cancer screening.**

Issue E21: **Failure, in some instances, to reflect correct or any information concerning the mandated benefits and coverage provisions for diabetes.**

Issue E22: **Failure, in some instances, to allow coverage for losses resulting from a covered person being under the influence of an intoxicant or a narcotic.**

Issue E23: **Failure, in some instances, to provide credit for previous coverage for any conditions or for certain named conditions.**

Issue E24: **Failure, in some instances, to reflect a correct definition of a pre-existing condition limitation.**

Issue E25: **Failure to reflect correct or complete information in the certificate of Creditable Coverage used by the Company.**

Issue E26: **Failure, in some instances, to reflect any fraud warning or a fraud warning that is substantially the same required wording on applications for insurance.**

Issue E27: **Failure to file a large group health policy marketed in Colorado during the period under examination.**

Issue E28: Failure, in some instances, to allow expenses incurred due to an accident while participating in any hazardous sports or hazardous occupations.

Issue E29: Failure, in some instances, to offer any coverage for alcoholism benefits or to offer benefits at least equal to minimum requirements.

Issue E30: Failure, in some instances, to provide benefits for biologically based mental illness and mental disorders.

Rates: The examiners identified one (1) area of concern in their review of rate filings by the Company.

Issue F1: Failure to file and use of unfiled rates.

Claims: The examiners identified two (2) areas of concern in their review of the claims handling practices of the Company.

Issue J1: Failure, in some instances to pay, deny or settle claims within the required time periods.

Issue J2: Failure, in some instances, to pay late payment interest and/or penalties due on claims.

FACTUAL FINDINGS

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure to file the Annual Report of Certification of Forms.

Section 10-16-107.2, C.R.S., Filing of health policies, states in part:

> (1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall *submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado*. Such listing shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner. [Emphasis added.]

Colorado Insurance Regulation 1-1-6, Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", promulgated under the authority of §§ 10-1-109, 10-4-419, 10-4-633, 10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states in part:

> . . .
>
> Section 4. Definitions
>
> For the purposes of this regulation:
>
> . . .
>
> D. "Annual Report for health coverage" shall mean a list of all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms.
>
> . . .
>
> F. "Certification of compliance" shall mean a certification form, which contains elements of certification as determined by the Commissioner, signed by a designated officer of the entity. If the individual signing the certification is other than the president, vice president assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, general counsel or an actuary that is also a corporate officer, documentation should be included that shows that this individual has been appointed as an officer of the

organization by the Board of Directors. This documentation is to be submitted with every filing.

Section 5. Rules

. . .

C. *Not later than December 31 of each year, each entity providing health care coverages shall file an Annual Report of policy forms including a fully executed certificate of compliance*. However, excess loss insurance, used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act", does not require the filing of an Annual Report of policy forms. [Emphasis added.]

D. Elements of Certification

The elements of certification as determined by the Commissioner, *which must be included in the Colorado Health Coverage Certification Forms, . . .* [Emphasis added.]

1. The name of the entity;

2. A statement that the officer signing the certification form is knowledgeable of accident and health insurance or health care benefits, . . . [Emphasis added.]

3. A statement that the officer signing the certification form has carefully reviewed the policy forms, subscription certificates, membership certificates, preneed funeral contracts or other evidences of health care coverage identified on the Listing of New Policy Forms *or Annual Report*, . . . [Emphasis added.]

4. A statement that the officer signing the certification form has read and understands each applicable law, regulation and bulletin;

5. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract;

6. A statement that the officer signing the certification form certifies:

. . .

b. For Annual Reports of health coverage, that the documents identified on the listing provide all applicable mandated coverages and are in full compliance with all Colorado insurance laws and regulations;

. . .

7. The name and title of the officer signing the certification form and the date the certification form is signed;

8. The original signature of the officer. Signature stamps, photocopies or a signature on behalf of the officer are not acceptable. Electronic signatures must be in compliance with CRS 24-71.3-102 and applicable regulations.

United was not in compliance with Colorado insurance law in that the Company had not submitted the required annual report to the Commissioner listing any policy form, endorsement, rider or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado.

Recommendation No 1:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-107.2 C.R.S. and Colorado Insurance Regulation 1-1-6. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its processes and fully implemented procedures to ensure that the Annual Report of Certification of Forms is filed as required by Colorado insurance law.

Issue A2: Failure to automatically issue Certificates of Creditable Coverage.

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority granted in §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

. . .

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in the federal regulations incorporated below.

. . .

3. *The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.*: [Emphasis added.]

   45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). These sections concern the method for counting creditable coverage; requirements for providing certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates; and *requirements for providing certificates of creditable coverage to those who were insured under individual plans,* including the form and content of the certificates. [Emphasis added.]

4. Later amendments to, or editions of, the above-referenced federal regulations are not included in this regulation. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated federal regulations which begins in Volume 62, number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

5. Copies of the incorporated federal regulations may be obtained or examined from the Commissioner's office by contacting the Assistant to the Commissioner at 1560 Broadway, Suite 850, Denver, Colorado, 80202. The above-referenced federal regulations may also be examined at any state publications depository library.

United was not in compliance with Colorado insurance law in that it did not automatically issue Certificates of Creditable Coverage upon termination of coverage as required by Colorado Insurance Regulation 4-2-18, which incorporates federal law. Requiring insureds to request issuance of Certificates of Creditable Coverage rather that automatically issuing them within a reasonable timeframe does not meet the requirements of Colorado insurance law.

Recommendation No. 2:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Insurance Regulation 4-2-18. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing its compliance.

Otherwise, United shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its processes to ensure that it automatically issues Certificates of Creditable Coverage upon termination of coverage as required by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure, in some instances, to reflect a correct or complete description of the mandated benefits for mammography screening.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (4) Low-dose mammography.
>
> (a) . . . Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article *and shall not be subject to policy deductibles. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. . . .* [Emphasis added.]

United was not in compliance with Colorado insurance law in that rider BRO51M, providing an "Additional Definition" and "Benefits for Mammography" contained an incorrect description of the required coverage amount for mammograms and did not reflect whether benefits are determined on a calendar year or a contract year. There is a minimum benefit amount required under Colorado insurance law and this benefit is adjusted annually on September 1st. Coverage for mammography shall be the lesser of this minimum benefit amount or the actual charge.

The minimum benefit amount that was established by Colorado insurance law is as follows:

From September 1, 2008 through August 31, 2009, the benefit amount was $96.16.
From September 1, 2009 through August 31, 2010, the benefit amount was $100.00.

Additionally there was nothing reflected to indicate that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy or whether benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis.

The following was reflected on the one (1) page rider:

> BENEFITS FOR MAMMOGRAPHY
>
> We will pay the expense incurred *up to $60.00* for routine and certain diagnostic screening by Low-Dose Mammography for the presence of breast cancer in a covered adult woman according to the following schedule. [Emphasis added.]
>
> Age 35 to 39: One baseline mammogram.
> Age 40 to 49: One mammogram every 2 calendar years but at least once each calendar year for a woman with risk factors for breast cancer as determined by her physician.

Age 50 to 65: One mammogram each calendar year.

All benefits are subject to any copayment and coinsurance provisions of the attached policy. This benefit is also subject to dollar limit provisions of the attached policy.

Surgical Medical Expense policy GSP3 was not in compliance with Colorado insurance law in that an incorrect description of the required coverage amount was reflected for mammograms. There is a minimum benefit amount required under Colorado insurance law and this benefit is adjusted annually on September 1. Coverage for mammography shall be the lesser of this minimum benefit amount or the actual charge, not 80% of incurred charges up to a maximum benefit amount.

Additionally there was nothing reflected in the policy's mammography benefits to indicate that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy or to specifically indicate that this benefit is exempt from any deductible.

Page 9 of policy GSP3 reflected:

For a mammography examination not covered under PARTS 1-10 of this policy, *We will pay a sum of money equal to 80% of the incurred charge*, but not to exceed a maximum benefit of $92.73* for each covered mammography examination provided that Covered Person. [Emphasis added.]

*This benefit shall be updated annually to reflect the most recent annual national Consumer Price Index-Urban (CPI-U) published by the U.S. Bureau of Labor and Statistics.

Basic Hospital & Surgical Expense policy CS1 and Hospital & Surgical Expense policy GSP2 were not in compliance with Colorado insurance law in that an incorrect description of the required coverage amount was reflected. There was nothing in policy CS1 to indicate that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy. Benefits for mammography are not subject to a deductible nor paid on a percentage basis and the coverage language reflected that this benefit is subject to the policy's provisions which include a deductible and coinsurance of 80%. Nothing was reflected to indicate that mammography benefits shall be determined on a calendar year or a contract year basis and this is to be specified in the policy or contract.

Page 9 of policy CS1 reflected:

PART V BENEFITS FOR MAMMOGRAPHY

Eligible Expenses incurred by a Family Member for mammography services will be covered up to $60 per exam when prescribed by a Physician, according to the following guidelines:

(1) One baseline mammogram for women age 35 to 39 inclusive;

(2) A mammogram for women age 40 to 49, inclusive every 2 years or more frequently if recommended by the Family Member's physician.

(3) A mammogram every year for women age 50 or over.

This benefit is subject to this policy's provisions, limitations and exclusions.

Policy forms SMXC, GSP2, SHXC, HSXC-C, MMXC and SSXC did not reflect any benefits for the mandated coverage of mammography screening.

Mammography Benefits rider BRO81M, used with certificate GRGSP2C, was not in compliance with Colorado insurance law in that nothing was found to indicate that the lesser of a minimum benefit or the actual charge is to be covered, nothing is reflected as to whether benefits shall be determined on a calendar year or a contract year, nothing was reflected to indicate that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the plan and nothing is reflected to indicate that this benefit is not to be subject to policy deductibles.

The following was reflected on the one (1) page rider:

ADDITIONAL DEFINITION

LOW-DOSE MAMMOGRAPHY means the x-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

MAMMOGRAPHY BENEFITS

We will pay the expenses incurred by a covered woman for a screening by Low-Dose Mammography for the presence of breast cancer according to the following schedule:

a) One baseline mammogram for a covered woman who is 35 years of age or older and under 40 years of age;

b) A mammogram each year for a covered woman who is 40 years of age or older.

ADDITIONAL LIMITATIONS AND EXCLUSIONS

The attached policy does not cover loss due to any expense incurred in excess of the usual, customary and regular charges for any service or materials in the geographic area where furnished.

Form Name	Form Number	Exempt Date
Rider-Additional Definition & Benefits For Mammography	BRO51M	12/04/1999 Date of Filing
LB Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
LB Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1983

Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Rider: Mammography Benefits Used with Hospital and Surgical Expense Large Group Retiree Health Certificate	BRO81M GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 3:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised the content of all applicable riders, certificates and any other policy forms to reflect the correct mandatory coverage provisions required for mammography screening as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant mammography screening benefits and provide the proposed date that the forms will be put in use.

Issue E2: Failure to reflect a complete, or in some instances, any description of the required coverage to be provided for annual prostate cancer screenings.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (10) Prostate cancer screening.
>
> (a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, *shall provide coverage for annual screening for the early detection of prostate cancer* in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of *this article shall not be subject to policy deductibles. S*uch coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. Such benefit shall *in no way diminish or limit diagnostic benefits otherwise allowable under a policy.* This coverage shall be provided according to the following guidelines: [Emphases added.]

United's rider, BRO51P, providing an "Additional Definition" and "Benefits for Prostate Cancer Screening" was not in compliance with Colorado insurance law in that an incomplete description of the required coverage for annual prostate screenings was reflected. The rider did not indicate that the coverage provided is to be exempt from policy deductibles and did not include the provision that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy.

The Company's policy GSP1 was not in compliance with Colorado insurance law in that it used rider BRO51P to provide a description of the coverage for annual prostate screenings.

Policies CS1, GSP2, SHXC, HSXC-C, MMXC, SSXC and Retiree Health Benefit Plan Certificates TRHPC and ERHPC-CO were not in compliance with Colorado insurance law as they did not include any information concerning the mandated benefit and coverage provisions for prostate cancer screening, which is to be provided for men over the age of fifty and men over the age of forty years who are in high-risk categories.

The following was reflected on the one (1) page Rider:

> PROSTATE CANCER SCREENING COVERAGE
>
> We will pay the expense incurred up to $65.00 per prostate screening for a covered man according to the following schedule:
>
> Age 40 to 49: One prostate screening per year for a covered man who is at increased risk of developing prostate cancer as determined by his physician.

Age 50 and up: One prostate screening per year.

Rider BR081PC, used with policy GRGSP2C, was not in compliance with Colorado insurance law in that the benefits expressed for prostate cancer screenings were incorrect and incomplete in the following ways:

Incorrect:

Colorado insurance law has a set amount which is used to calculate the benefit amount that will be paid. The lesser of this amount of sixty-five dollars or the actual charge for the screening is to be paid.

The rider indicated that a deductible is to be applied prior to application of any copayments or coinsurance provisions for prostate cancer screenings, which is to be provided for men over the age of fifty and men over the age of forty years who are in high-risk categories. Colorado insurance law mandates prostate cancer screenings are to be exempt from a deductible.

Incomplete:

The rider did not clearly reflect the guidelines or coverage provisions for the mandated benefit that is to be provided.

There was nothing reflected to indicate that this benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy.

The one (1) page rider reflected:

> PROSTATE CANCER SCREENING BENEFIT
>
> We will pay the expense incurred for a prostate cancer screening for a covered man under the attached policy or certificate, in accordance with the current American Cancer Society screening guidelines for the ages, family histories, and frequencies referenced in such guidelines.
>
> All benefits are subject to any copayment and coinsurance provisions of the attached policy or certificate. This benefit is also subject to any deductibles or dollar limit provisions which may appear in the attached policy or certificate.

Form Name	Form Number	Effective Date
Rider-Additional Definition & Benefits For Prostate Cancer Screening	BR051P	12/04/1999
Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98

Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Rider-Prostate Cancer Screening Benefit Hospital & Surg Expense	BR081PC GRGSP2C	Filed with the District Of Columbia Department of Insurance 05/25/05. Never filed in Colorado.
Teamsters Retiree Health Plan Certificate (Large Group)	TRHPC	Submitted: 08/14/96 Stamped: 08/22/96
Employer Retirement Health Plan Certificate (Large Group)	ERHPC-CO	Submitted: 07/08/97 Stamped: 07/17/97

Recommendation No. 4:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised its riders, certificates and all applicable policy forms to reflect a complete description of the benefits for prostate cancer screenings as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant prostate cancer screening benefits and provide the proposed date that the forms will be put in use.

Issue E3: Failure, in some instances, to reflect the correct provisions under which coverage is to be provided for newborn dependents or a child placed for adoption.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn children.

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article *shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth*. [Emphasis added.]

. . .

(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth *in order to have the coverage continue beyond such thirty-one-day period.* [Emphasis added.]

. . .

(6.5) Adopted child – dependent coverage.

(a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, the entity shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber, *regardless of whether adoption of the child is final*. [Emphasis added.]

Bulletin No. B-4.6, Mandatory Newborn Coverage and Premiums, states in part:

I. Background and Purpose

The purpose of this bulletin is to provide clarification regarding newborn coverage requirements and the collection of required premium as required in the Newborn Act, § 10-16-104(1), C.R.S. The Division of Insurance recognizes that the business of insurance has changed significantly since the Newborn Act was passed in 1975. The Act was initially intended to require coverage for newborn dependent children from the date of birth, prohibiting carriers from applying waiting periods before coverage could be effective or from applying pre-existing condition limitations for newborns.

The prevalence of managed care in the marketplace today, as well as other local and federal changes, including mandatory coverage of well child care and limits on pre-existing exclusions makes the interpretation of the Act more complex. After reviewing concerns raised by the industry, the Division has reviewed both the intent of the law, as well as proper application, in the current health insurance environment.

> Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.
>
> . . .
>
> III. Division Position
>
> *It is the responsibility of the carrier to provide health coverage for newborn dependent children from the date of birth*. In order for coverage to extend beyond the first thirty-one days, a carrier may require notification and payment of the required premiums within thirty-one days of the newborn dependent child's birth. [Emphasis added.]
>
> A. Coverage during the first thirty-one days.
>
> *Coverage must be provided automatically upon birth, continuing through the thirty-first day, without requiring notification or payment of premium*. Such coverage shall be provided for the first thirty-one days of life and shall include all coverage available under the policy, including coverage for well-baby services as mandated in § 10-16-104 (11), C.R.S. [Emphasis added.]

United's GSP3, SMXC, CS1, GSP1, GSP2, MMGAP, SHXC and HSXC-C policies were not in compliance with Colorado insurance law in that an incorrect requirement was reflected for the automatic coverage to be provided for the first thirty-one (31) days of a newborn's life or for a child placed for adoption. This coverage is to be provided without an insured having to make application within forty-five (45) days after birth or placement for adoption. For coverage to extend beyond the first thirty-one days, a carrier may require notification via an application and payment of the required premiums within thirty-one days of the newborn dependent child's birth.

Additionally, the policies reflected above were not in compliance with Colorado insurance law in that they excluded any charges for usual and customary routine nursery care, well-baby care, immunizations, medical examinations or tests of any kind or any other usual and customary routine care not incident and necessary to the treatment of an injury or sickness for newborns.

The SSXC policy reflected nothing concerning the mandatory coverage for newborns.

Policies HIXC and HMXC use rider R-NBC (1) to reflect Newborn Children's Provisions for coverage. This rider was more limiting than allowed by Colorado insurance law in that it required at least one dependent be covered as a Family Member under the policy, in order for the automatic thirty-one (31) days after birth coverage for a newborn to be effective.

Page 15 of policy GSP3 reflected:

> **POLICY PROVISIONS**
>
> A child of Yours born or adopted after the effective date of this policy will be covered as a Family Member from and after the moment of birth or adoption providing: (1) You make application within 45 days after birth or adoption; and . . .

Page 6 of policy SMXC reflected:

NEWBORN CHILDREN'S PROVISION

PART 9

A child of Yours born after the effective date of this policy will be covered as a Family Member from and after the moment of birth providing: (1) (You make application within 45 days after birth; and …

Page 14 of policy GSP3 reflected:

LIMITATIONS AND EXCLUSIONS

Except to the extent specifically and directly provided elsewhere in this policy to the contrary, We will not pay benefits under this policy for:

. . .

2. Any charges for (1) usual and customary routine nursery care; or (2) well-baby care, immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness; or

Page 6 of policy SMXC reflected:

NEWBORN CHILDREN'S PROVISION

PART 9

This policy does not cover: (1) usual and customary routine nursery care; or (2) well-baby care; immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness.

Page 9 of policy CS1 reflected:

PART IV NEWBORN CHILDREN'S PROVISION

A child of Yours born after the effective date of this policy will be covered as a Family Member from the moment of birth providing: (1) You make application within 45 days after birth; and (2) You pay the required additional premium within 30 days after You are notified of the premium amount due.

Any waiting period applicable to eligibility of coverage of a Family Member is deleted with respect to the newborn child.

Page 7 of policy GSP1 reflected:

PART 11 NEWBORN/NEWLY ADOPTED CHILDREN'S PROVISION

A child of Yours born or adopted after the effective date of this policy will be covered as a Family Member from and after the moment of birth or adoption providing: (1) You make application within 45 days after birth or adoption; and (2) You pay the required additional premium within 30 days after You are notified of the amount.

Any waiting period applicable to eligibility of a Family Member is deleted with respect to the child.

This policy does not cover: (1) usual and customary routine nursery care; or (2) well-baby care; immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness.

Page 7 of policy GSP2 reflected:

PART 9 LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this policy for:

. . .

2. Usual and customary routine nursery care, or well-baby care or immunizations, except as provided under Part 5 of this policy; or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness;

Page 6 of policy GSP2 reflected:

PART 5 OUTPATIENT PHYSICIAN EXPENSE BENEFIT

We will pay benefits for expenses incurred due to injury or Sickness for outpatient treatment by a Physician of You or a Family Member at the Physician's office, clinic, a hospital (on an outpatient basis), or at home.

1. For treatment because of Injury or Sickness which does not require a surgical operation: Benefits will be paid at the rate of 80% of the fee charged by the Physician, not to exceed the Outpatient Physician Expense Benefit for each Physician's treatment and for not more than one Physician's treatment per day, and not to exceed the Outpatient Physician Expense Maximum for any one Injury or Sickness; and

2. For a physical exam, benefits will be equal to 80% of the fee charged by the Physician, not to exceed the Physical Exam Benefit and not more than one physical exam per year.

The total of (1) and (2) are not to exceed the Outpatient Physician Expense Maximum during any policy year.

For treatment because of Injury or Sickness which requires a surgical operation, We will pay the benefit provided in (1) above or the Benefits for Surgical Operations in Part 3, whichever is greater.

Rider form R-NBC (1), "Newborn Children's Provision" reflected:

A child of the Insured born while this policy is in force and while at least one dependent is covered as a Family Member under this policy, upon application by the Insured within 45 days after birth and the payment of the required additional premium within 30 days after the Insured is notified of the amount due, such child will be covered as a Family Member from and after the moment of birth to the extent provided by this policy for Family Members.

Any waiting period applicable to eligibility of a Family Member is hereby deleted with respect to such child; however, this policy does not cover usual and customary routine nursery care, well-baby care, immunizations, medical examinations, tests of any kind or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of a covered injury or sickness.

Page 3 of policy MMGAP reflected:

PART 3 LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this policy for:

. . .

4. Usual and customary routine nursery care, or well-baby care or immunizations; or any other usual and customary routine care and treatment following full, term or premature birth, not incident and necessary to the treatment of Injury or Sickness;

Page 4 of policy MMGAP reflected:

POLICY PROVISIONS

A child of Yours born or adopted after the Effective Date of this policy will be covered as a Family Member from and after the moment of birth or adoption providing: (1) You make application within 45 days after birth or adoption; and (2) You pay the required additional premium within 30 days after You are notified of the amount. Any waiting period applicable to eligibility of a Family Member is deleted with respect to the child.

Page 5 of policy SHXC reflected:

> PART 7 NEWBORN CHILDREN'S PROVISION
>
> A child of Yours born after the effective date of this policy will be covered as a Family Member from the moment of birth providing: (1) You make application within 45 days after birth; and (2) You pay the required additional premium within 30 days after You are notified of the amount.
>
> Coverage for the newborn child shall consist of coverage for Injury or Sickness as provided by this policy including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities (including the care and treatment for cleft lip and/or cleft palate).
>
> Any waiting period applicable to eligibility of a Family Member is deleted with respect to the newborn child.
>
> This policy does not cover: (1) usual and customary routine nursery care; or (2) well-baby care; immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth.

Page 7 of policy HSXC-C reflected:

> NEWBORN CHILDREN'S PROVISION
>
> A child of Yours born after the effective date of this policy will be covered as a Family Member from and after the moment of birth providing: (1) You make application within 45 days after birth; and (2) You pay the required additional premium within 30 days after You are notified of the amount.
>
> Any waiting period applicable to eligibility of a Family Member is deleted with respect to the child.
>
> This policy does not cover: (1) usual and customary routine nursery care; or (2) well-baby care: immunizations, medical examinations or tests of any kind; or (3) any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness.

The certificate for policy GRGSP2 was not in compliance with Colorado insurance law in that it reflected an exclusion for any charges for usual and customary routine nursery care or well-baby care or immunizations or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness. It was noted that rider BRO81CP that was filed at the same time the certificate was filed contradicted this exclusion.

Additionally, an incorrect requirement was reflected for the automatic coverage to be provided from the moment of birth or adoption. This coverage is to be provided without an insured having to make application within forty-five (45) days after birth or adoption. For coverage to extend beyond the first thirty-one days, a carrier may require notification via an application.

Page 8 of the certificate reflected:

PART 9 LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this Certificate for:

. . .

2. Usual and customary routine nursery care, or well-baby care or immunizations, except as provided under Part 5 of this Certificate; or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness;

CERTIFICATE PROVISIONS

. . .

A child of Yours born or adopted after the effective date of this Certificate will be covered as a Family Member from and after the moment of birth or adoption providing: (1) You make application within 45 days after birth or adoption; and (2) You pay the required additional premium within 30 days after You are notified of the amount. Any waiting period applicable to eligibility of a Family Member is deleted with respect to the child.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Hospital Indemnity	HIXC	Resubmitted: 05/24/76 Stamped: 05/26/76
Hospital Indemnity	HMXC	Submitted: 09/14/79 Stamped: 09/18/79
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
Rider: Newborn Children's Provision	R-NBC (1)	Submitted: 04/01/75 Stamped: 04/07/75
LB Hospital Surgical Expense	MMGAP	Submitted: 09/17/07

		Stamped: 10/10/07
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 5:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has implemented procedures to ensure that its contract form, rider, certificates and any other policy forms reflect the automatic coverage to be provided for newborns and children placed for adoption as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant coverage provisions for newborns and children and provide the proposed date the forms will be put in use.

Issue E4: Failure to allow reimbursement for covered services when lawfully performed by a licensed provider that is a family member or who resides in the insured's household.

Section 10-16-104., C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (7) Reimbursement of providers.
>
> (a) Sickness and accident insurance.
>
> (I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.* … [Emphasis added.]

United's GSP3 and SMXC, HIXC, HMXC, CS1, GSP1, GSP2, MMGAP, SHXC, HSXC-C, MMXC policies, SSXC rider R-DOPR, the certificate for policy GRGS2C and policy UA-250 were not in compliance with Colorado insurance law in that they reflected an exclusion for coverage for services performed by a provider that is a member of the insured person's immediate family or who resides in the insured person's home. A policy may contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services; nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, (e.g., an immediate family member or resides in household).

Page 4 of policy GSP3 reflected:

Definitions

> **Physician** and **Doctor** mean a person duly licensed in the United States and duly qualified to provide care, treatment, services, or supplies for the Injury or Sickness that is the subject of Your claim, or the additional conditions or disorders, or diagnostic services, which are specifically covered under PART 7 of this policy, *Physician or Doctor does not include You or any member of Your household or immediate family*. [Emphasis added.]

Page 2 of policy SMXC reflected:

DEFINITIONS

> PHYSICIAN means a person legally licensed to treat Injury or Sickness, *other than You or any member of Your immediate family*. [Emphasis added.]

Page 1 (pages not numbered) of policies HIXC and HMXC reflected:

> PHYSICIAN means a person who is legally licensed to treat [such] injury or sickness other than the Insured, a Family Member or a member of the Insured's immediate family.

Page 2 (pages not numbered) of policy HIXC reflected:

> PART 4 ADDITIONAL DAILY HOSPITAL INDEMNITY BENEFITS-PRIVATE DUTY REGISTERED NURSE (R.N.) IN-HOPSITAL
>
> If, as a result of such injury or such sickness, a Family Member shall require, upon the recommendation of a physician, the full time private duty care and attendance of a Registered Nurse (R.N.) (Registered Nurses who are Family Members or members of Insured's immediate family or household are excluded) …

Page 4 of policy CS1 reflected:

> PHYSICIAN means a person, other than You or any member of Your Immediate Family, legally licensed to practice medicine, while practicing within the scope of his or her license.

Pages 8 & 9 of policy CS1 reflected:

> PART 11 HOSPITAL AND SURGICAL EXPENSE BENEFITS
>
> I. EXPENSES FOR PRIVATE DUTY NURSING SERVICES
>
> . . .
>
> Charges for Services provided by You or a member of Your household or Immediate Family are not Eligible Expenses under this Part II.I
>
> J. EXPENSES FOR AMBULANCE SERVICE
>
> . . .
>
> Charges for Services provided by You or a member of Your household or Immediate Family are not Eligible Expenses under this Part II.J.
>
> PART V1 LIMITATIONS AND EXCLUSIONS
>
> . . .
>
> 2. No benefits are payable for any medical treatment or service for which a Family Member does not incur a charge or charges which would not have been made if You had no insurance. No benefits are payable for any services or supplies performed or provided by you or your household or Immediate Family.

Page 2 of policies GSP1 and GSP2 reflect:

Physician means a person legally licensed to treat Injury or Sickness, other than You or any member of Your immediate family.

Page 6 of policy GSP1 reflected:

PART 6 BENEFITS FOR PRIVATE DUTY REGISTERED NURSE (R.N.) SERVICES IN-HOSPITAL

. . .

We will not pay benefits for services provided by You or a Member of Your immediate household or family.

Page 7 of policy GSP2 reflected:

PART 6 BENEFIT FOR IN-HOSPITAL REGISTERED NURSE

. . .

We will not pay benefits for services provided by You or a member of Your immediate household or family.

Page 2 of policy MMGAP reflected:

DEFINITIONS

PHYSICIAN means a person legally licensed to treat Injury or Sickness, other than You or any member of Your immediate family.

Page 2 of policy SHXC reflected:

DEFINITIONS

PHYSICIAN means a person, other than You or any member of Your immediate family, legally licensed to practice medicine.

Page 6 of policy HSXC-C reflected:

PART 6 BENEFITS FOR PRIVATE DUTY REGISTERED NURSE (R.N.) SERVICES IN-HOSPITAL

. . .

We will not pay benefits for services provided by You or a member of Your immediate household or family.

Page 1 (pages not numbered) of policies MMXC and SSXC reflect:

DEFINITIONS

PHYSICIAN means a person who is legally licensed to treat such injury or such sickness other than the Insured, a Family Member or a member of the Insured's immediate family.

Page 3 (pages not numbered) of policy MMXC reflected:

PART 6 BENEFITS FOR PRIVATE DUTY REGISTERED NURSE (R.N.) SERVICES IN-HOSPITAL

If as a result of such injury or such sickness, a Family Member shall require, upon the recommendation of a physician, the full time private duty care and attendance of a Registered Nurse (R.N.*) (Registered Nurses who are Family Members or members of Insured's immediate family or household are excluded)* . . .[Emphasis added.]

The following is reflected on the one (1) page rider R-DOPR:

This rider amends the policy to which it is attached as follows:

The term "Physician" or "licensed physician or surgeon" means a person who is legally licensed to treat such injury or such sickness other than the Insured, a Family Member, a member of the Family Group, or a member of the Insured's immediate family.

Page 3 of the certificate for policy GRGSP2C reflected:

DEFINITIONS

PHYSICIAN means a person legally licensed to treat Injury or Sickness, other than You or any member of Your immediate family.

Page 7 of the certificate for policy GRGSP2C reflected:

PART 6 BENEFIT FOR IN-HOSPITAL REGISTERED NURSE

. . .

We will not pay benefits for services provided by You or a member of Your immediate household or family.

Page 2 of policy UA-250 reflected:

DEFINITIONS

PHYSICIAN means a person legally licensed to treat Injury or Sickness, other than You or any member of Your immediate family.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008

Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1983
Hospital Indemnity	HIXC	Resubmitted: 05/24/76 Stamped: 05/26/76
Hospital Indemnity	HMXC	Submitted: 09/14/79 Stamped: 09/18/79
Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Hospital & Surgical Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
Hospital & Surgical Expense	MMGAP	Submitted: 09/17/07 Stamped: 10/10/07
Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Rider	R-DOPR	Filed: 12/17/1974 Stamped: 12/27/1974
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.
Accident Expense Policy	UA-250	Submission: 08/04/93 Stamped: 06/07/94

Recommendation No. 6:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised the definitions of health care providers in all applicable forms to remove the exclusion for reimbursement of licensed providers who are family members, or who reside in the covered person's home, as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant provision for expense reimbursement and provide the proposed date that the forms will be put in use.

Issue E5: Failure, in some instances, to allow coverage for hospitalization and general anesthesia for dental procedures for qualified dependent children.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(12) Hospitalization and general anesthesia for dental procedures for dependent children.

(a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except supplemental policies that cover a specific disease or other limited benefit *shall provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to Section 25-3-101, C.R.S.,* and for associated hospital or facility charges *for dental care provided to a dependent child,* as dependent is defined in section 10-16-102(14), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

(I) The child has a physical, mental, or medically compromising condition; or

(II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or

(III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or

(IV) The child has sustained extensive, orofacial and dental trauma.

United's policy GSP3, reflected an exclusion that is contradictory to the benefits required by Colorado insurance law and provided in the policies for hospitalization and general anesthesia for dental procedures for dependent children.

Page 14 of policy GSP3 reflect:

LIMITATIONS AND EXCLUSIONS

. . .

4. Any dental treatment (except as necessitated by Injury), . . .

Policies SMXC, CS1 and GSP2 were not in compliance with Colorado insurance law in that they exclude coverage for dental treatment for any covered persons. Colorado insurance law mandates coverage for

hospitalization and general anesthesia for dental procedures for dependent children that meet certain criteria.
Page 6 of policy SMXC reflected:

LIMITATIONS AND EXCLUSIONS

. . .

7. Dental treatment (including dental x-rays).

Page 10 of policy CS1 reflected:

LIMITATIONS AND EXCLUSIONS

. . .

15. No benefits are payable for dental treatments unless due to injury to sound teeth which occur while the Family Member is insured under this policy; …

Page 7 of policy GSP2 reflected:

LIMITATIONS AND EXCLUSIONS

. . .

3. Dental treatment, . . .

Form Name	Form Number	Date of Filing
LB Surgical Medical Expense	GSP3	Submitted: 08/18/08 Stamped: 09/17/08
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1983
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04

Recommendation No. 7:

United shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing that it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence that it has corrected all applicable policy forms to reflect the mandated coverage to be provided for hospitalization and general anesthesia for dental procedures for dependent children as required by Colorado insurance law. Within these sixty (60) days, United will also provide the Division with specimen copies of all revised policy forms containing compliant benefits for hospitalization and general anesthesia for dental procedures for dependent children and provide the proposed date that the forms will be put in use.

Issue E6: Failure, in some instances, to reflect the mandated benefit for cervical cancer vaccines for all females for whom a vaccination is recommended.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(17) Cervical cancer vaccines.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, *shall provide coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the United States department of health and human services*. [Emphasis added.]

(b) *The requirements of this subsection (17) shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued, renewed or reinstated on or after January 1, 2008*, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated on or after January 1, 2008. [Emphasis added.]

Policies CS1, GSP1, GSP2, SHXC, HSXC-C, MMXC, and SSXC were not in compliance with Colorado insurance law in that the mandated benefit for cervical cancer vaccines, for all females for whom a vaccination is recommended, was not reflected.

Form Name	Form Number	Date of Filing
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76

LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73

Recommendation No. 8:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised its processes and fully implemented procedures to ensure that applicable forms reflect coverage for the mandated benefit of cervical cancer vaccines as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant cervical cancer vaccine benefits and provide the proposed date that the forms will be put in use.

Issue E7: Failure to reflect correct benefits, or in some instances, any benefits for child health supervision services.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(11)(a) *For purposes of this subsection (11), unless the context otherwise requires, "child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2),* to dependent children up to age thirteen. Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician. [Emphasis added.]

(b) *An individual,* small group, or large group *health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services.* A plan described in this paragraph (b) may provide that child health supervision services rendered during a periodic review shall only be covered to the extent such services are provided during the course of one visit by or under the supervision of a single physician, physician's assistant, or registered nurse. [Emphasis added.]

(c) *Benefits for child health supervision services shall be exempt from a* deductible or *dollar limit provision in any individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident and such exemption shall be explicitly stated in such a plan.* [Emphasis added.]

Emergency Regulation 08-E-12 (effective 1/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

. . .

Section 2 Scope and Purpose

The purpose of this emergency regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This emergency regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider plan (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

Colorado Insurance Regulation 4-6-5 (effective 2/1/09), Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal prevention services. This regulation specifies the requirements for the basic and standard health benefit plan as well as other requirements for small employer carriers. This regulation replaces Emergency Regulation 08-E-12 in its entirety.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

February 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider plan (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

Footnote 6 See attachment 1 for list of covered preventive services. Immunizations for children up to age13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4.24.

Attachment 1

COVERED PREVENTIVE SERVICES [1]	
All Children	Immunizations. Immunization deficient children are not bound by "recommended ages".
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery. 6 well-child visits [2] 1 PKU
Age 13-35 months	3 well-child visits
Age 3-6	4 well-child visits
Age 7-12	4 well-child visits

[1] Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

[1a] Age limitations as recommended by the U.S. Department of Health and Human Services' Advisory Committee on Immunization Practices.

[2] "Well-child visit" means a visit to a primary care provider that includes the following elements: Age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. The schedule of these visits, through age 12, is based on the recommendations of the American Academy of Pediatrics.

United was not in compliance with Colorado insurance law in that its policy GSP3, reflected incomplete and incorrect benefits for Child Health Supervision Services.

Additionally, policies SMXC, CS1, GSP1, GSP2, MMGAP, SHXC, HSXC-C, MMXC and SSXC were not in compliance with Colorado insurance law as they did not reflect any of the mandated benefits for Child Health Supervision Services.

Incomplete:

- Nothing is reflected to indicate the number of well-child visits for each of four (4) age categories.
- Nothing is reflected to indicate that immunization deficient children are not bound by "recommended ages."
- Nothing is reflected concerning the one (1) newborn home visit during the first week of life if a newborn is released from the hospital less than 48 hours after delivery.
- Nothing is reflected concerning the mandated PKU for age 0-12 months.

Incorrect:

Child Health Supervision Services are not subject to a dollar limit provision.

- The policy reflected that services attributable to a history, physical examination, developmental assessment anticipatory guidance, or any combination thereof will be paid as if such services were for a covered physician's wellness exam which is capped at $50.00.
- The policy reflected that when services attributable to a history, physical examination, developmental assessment, anticipatory guidance, or any combination thereof are provided, they shall not exceed the Doctor Office Visit Yearly Maximum of $250.00.
- The policy language limited each visit to $250.00 for each periodic visit during which either immunizations, laboratory tests, or both are provided to or for any one covered family member under thirteen (13) years of age.

Contradictory Statement:

- Although the policies reflected that this child health supervision service benefit is exempt from any co-insurance provision, the policy language referred to payment of 80% of incurred expenses for immunizations, laboratory tests, or both.

Page 11 of policy GSP3 reflected:

> . . .
>
> 10. CHILD HEALTH SUPERVISION SERVICES BENEFIT
>
> We will provide a benefit for expenses incurred by You or a covered Family Member for Child Health Supervision Services provided to a covered Family Member from the moment of birth up to an age of thirteen (13) years. Child Health Supervision Services are the following services, delivered by or under the supervision of a Physician, who is a medical doctor or doctor of osteopathy, during periodic visits: a history, physical examination, a developmental assessment and anticipatory guidance, appropriate immunizations, laboratory tests, or any combination thereof. To be covered, such services shall be provided in accordance with the prevailing medical standards consistent with the published Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

If the periodic visit is not otherwise covered under another PART of this policy, We will pay a benefit in accordance with the following:

a. For the expenses incurred for the services attributable to a history, physical examination, developmental assessment anticipatory guidance, or any combination thereof, *We will make payment as if such services were for a covered physician's wellness exam payable under PART 9(3).* This benefit will be provided for each such periodic visit. *The combined amount of payments made during any policy year for any one covered Family Member under thirteen (13) years of age for Doctor Office Visits payable under PART 9, as stated in the Benefit Schedule, and for periodic visits during which services attributable to a history, physical examination, developmental assessment, anticipatory guidance, or any combination thereof are provided, payable as set forth herein, shall not exceed the Doctor Office Visit Yearly Maximum stated in the Benefit Schedule.* [Emphasis added.]

b. For the expenses incurred for the services attributable to immunizations, laboratory tests, or both, *We will pay a sum of money equal to 80% of the incurred expenses, not to exceed a maximum benefit of $250.00 for each periodic visit during which either immunizations, laboratory tests, or both are provided to or for any one covered Family Member under thirteen (13) years of age.* [Emphasis added.]

This benefit is exempt from any deductible, co-pay or *co-insurance provision* of this policy. [Emphasis added.]

United rider BRO81C, filed with the certificate for policy GRGSP2, was not in compliance with Colorado insurance law in that incomplete and incorrect benefits are reflected for Child Health Supervision Services.

Incomplete:

- Nothing was reflected to indicate that immunization deficient children are not bound by "recommended ages."

- Nothing was reflected concerning the one (1) newborn home visit during the first week of life if a newborn is released from the hospital less than 48 hours after delivery.

Incorrect:

- The Rider reflected that benefits are subject to any deductibles or dollar limit provisions in the attached policy or certificate. Child Health Supervision Services are not subject to deductibles or dollar limit provisions.

- The Rider reflected that expenses incurred for visits would be paid for children up to the age of twelve (12) years. Child health supervision services are to be paid up to the age of thirteen (13) years.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008

		Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1983
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital Surgical Expense	MMGAP	Submitted: 09/17/07 Stamped: 10/10/07
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Rider: Coverage For Child Preventive And Primary Care Services	BRO81CP	
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05 Never filed in Colorado

Recommendation No. 9:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., Colorado Emergency Regulation 08-E12 and Colorado Insurance Regulation 4-6-5. In the event United is unable to provide such documentation, the Company may submit, with its submissions or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised its applicable policy forms to reflect the correct mandated benefits for child health supervision services as required by Colorado insurance law.

Within these sixty (60) days, United shall also provide the Division with specimen copies of all forms revised to reflect correct child health supervision services and provide the proposed date the forms will be put in use.

Issue E8: Failure, in some instances, to reflect correct or complete benefits for home health services and hospice care coverage.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(8) Availability of hospice care coverage.

(a) As used in this subsection (8), unless the context otherwise requires:

(I) "Home health services" means home health services as defined in section 25.5-4-103(7), C.R.S., which are provided by a home health agency certified by the department of public health and environment.

(II) "Hospice care" means hospice services provided to a terminally ill individual by a hospice care program, licensed and regulated by the department of public health and environment pursuant to sections 25-1.5-103(1)(a)(I) and 25-3-101, C.R.S., or by others under arrangements made by such hospice care program.

. . .

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions *which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care*. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Colorado Insurance Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d),Colorado Revised Statutes (C.R.S.) states in part:

. . .

Section 2. Purpose

The purpose of this regulation is to *establish requirements for standard policy provisions, which state clearly and completely the criteria for and extent of coverage for home health services and hospice care and to facilitate prompt and informed decisions regarding patient placement and discharge.* [Emphasis added.]

. . .

Section 4. Requirements for Home Health Services

. . .

B. General Policy Provisions Pertaining to Home Health Care.

(1) The policy offering *shall provide that* home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization. *Prior hospitalization shall not be required.* [Emphases added.]

Section 5. Requirements for Hospice Care

A. Definitions.

(1) A "hospice" is a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative supportive, and interdisciplinary team services providing physical, psychological, spiritual, and bereavement care for terminally ill individuals and their families within a continuum of inpatient and home care available 24 hours, 7 days a week. *Hospice services shall be provided in the home, a licensed hospice, and/or other licensed health facility.* Hospice services include but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.

. . .

(4) A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, *the primary care giver and individuals with significant personal ties.* [Emphasis added.]

. . .

(12) “Home care services” are hospice services, which are provided in the place the *patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer* facility. [Emphases added.]

. . .

(15) “Hospice Levels of Care:”

. . .

(c) "Inpatient hospice respite care:" The level of care received when the patient is in a licensed facility *to provide the caregiver a period of relief. Inpatient respite care* may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less. [Emphasis added]

. . .

(18) A "*benefit period"* for hospice care services *is a period of three months,* during which services are provided on a regular basis. [Emphases added.]

B. General Provisions Pertaining to Hospice Care.

. . .

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, *except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period*. After the *exhaustion of three benefit periods,* the insurer's *case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.* [Emphases added]

C. Benefits for Hospice Care Services.

. . .

(3) The policy offering shall include *the following benefits,* subject to the policy's deductible, coinsurance and stoploss provisions, which *are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above*. [Emphasis added.]

(a) Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1150.

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management *and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above).* [Emphasis added]

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

United was not in compliance with Colorado insurance law in that its policy GSP3 did not express completely the extent of coverage to be provided for home health services in the following ways:

HOME HEALTH SERVICES

Incomplete

- The policy did not reflect the provision that prior hospitalization is not required in order to receive home health services.

- The provision that "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility, was not reflected.

Additionally, United was not in compliance with Colorado insurance law in that its policy GSP3 did not express correctly and completely the extent of coverage to be provided for hospice care services in the following ways:

HOSPICE CARE

Incorrect

- The policy reflected a benefit of $100.00 per day for a maximum period of six (6) months. The maximum benefit period reflected of six (6) months was not correct as this represents two (2) benefit periods. Should the patient continue to live beyond the prognosis for life expectancy, (two benefit periods), the benefits shall continue at the same rate for one additional benefit period and after the exhaustion of three (3) benefit periods, case management staff, the individual's attending physician and the hospice's medical director determine the appropriateness of continuing hospice care.

Incomplete

- The policy did not clearly reflect the fact that "hospice care services" are to be provided in the home, a licensed hospice, and/or other hospice facility.

- The Surgical Medical policy GSP3 did not reflect that a "benefit period" for hospice care services is a period of three (3) months, during which services are provided on a regular basis.

- The policy did not clearly reflect that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional period. Additionally, after the exhaustion of three (3) benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's medical director to determine the appropriateness of continuing hospice care.

- The policy reflected an incomplete definition for "family member" as it relates to the required Hospice Care benefits. Under the hospice care benefit provisions, the definition of a patient's family is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, *the primary care giver and individuals with significant personal ties.*

- Nothing is reflected in the policy to *clearly indicate* that the twelve *(12) benefits are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.*

- Nothing is reflected in the policy concerning the "inpatient hospice respite care," one of the hospice levels of care that is to be covered when provided on an intermittent, non-routine, short-term basis and that may be limited to periods of five days or less.

Page 3 of policy GSP3 reflected:

DEFINITIONS

FAMILY MEMBER means a person who is named in the application for coverage under this policy, other than the proposed Insured, or a person who has been added in accordance with the ELIGIBILITY AND INSURED'S TERMINATION provision.

HOSPICE CARE means hospice services provided to a terminally ill individual by a hospice care program licensed and regulated by the Department of Public Health and Environment, or by others under arrangements made by such hospice care program.

Page 13 of policy GSP3 reflected:

. . .

13. Hospice Care Benefits

A benefit for Hospice Care covered under this subpart of PART 12 will be paid as follows:

. . .

b. For Hospice Care Services not covered under PARTS 1-10 of this policy, nor brought within the scope of coverage based on (a) above, We will pay a sum of $100 per day for all provided services combined, up to a maximum of 6 months from the day Hospice Care Services were first provided for each Covered Person.

Page 13 of policy GSP3 reflected:

We will also provide a benefit for the expenses incurred for bereavement support services for You or a covered Family Member of a deceased Covered Person during the 12-month period following death, and for short-term general inpatient Hospice Care or continuous Home Health Services that may be required for pain control or symptom management, as recommended by a Physician, including the following:

1) Medical supplies;
2) Drugs and biological;
3) Prosthesis and orthopedic appliances;

4) Oxygen and respiratory supplies;
5) Diagnostic testing;
6) Rental or purchase of durable medical equipment;
7) Transportation;
8) Physician services;
9) Therapies including physical, occupational and speech; and
10) Nutritional counseling by a nutritionist or dietitian.

Policy SMXC uses riders R-CO (17) and HHC (5) 11/85 to reflected the benefits to be provided for home health services and hospice care. The riders were not in compliance with Colorado insurance law in that they did not reflect correct and complete benefits in the following ways:

Rider R-CO (17)

HOSPICE CARE

Incorrect

- The rider reflected a benefit level of $55.00 to be provided per day for hospice care services and supplies with a maximum coverage amount not to exceed $5,000 for a benefit period. Colorado insurance law mandates that a benefit of no less than $100 is to be provided per day for three (3) routine home care services and the total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.

- The rider reflected an incorrect period for bereavement support services, (three months), and an incorrect maximum benefit ($500.00). Bereavement support services for the family of the deceased are to be provided for twelve months following death and in no event is this maximum benefit to be less than $1150.

- The rider incorrectly limited the benefit of short-term general inpatient (acute) hospice care or continuous home care for a period of crisis, pain control or symptom management to a lifetime maximum of thirty (30) days. Colorado insurance law did not provide for a lifetime maximum number of days for this benefit.

- *Custodial care reflected as an exclusion* in the Limitation and Exclusion Section is in contradiction of what is required as covered expenses for a terminally ill person. All services provided for hospice recipients are primarily to maintain or support the patient, as the condition is not likely to improve.

Incomplete:

- The rider did not reflect that a patient is defined as having an anticipated life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three (3) benefit periods, case management staff, the individual's attending physician and the hospice's medical director determine the appropriateness of continuing hospice care.

- Nothing was reflected in the policies concerning the "inpatient hospice respite care," one of the hospice levels of care that is to be covered when provided on an intermittent, non-routine, short-term basis and that may be limited to periods of five days or less.

- Nothing was reflected in the rider indicating that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

- The rider did not reflect coverage for the hospice care benefit of "*transportation*" which is one of the twelve (12) benefits subject to the deductible, coinsurance and stoploss provisions, but is exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

- There was nothing reflected in the rider to indicate that the twelve (12) benefits, which are subject to the deductible, coinsurance and stoploss provisions, are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

Page one (1) of the two (2)-page rider reflected:

HOSPICE CARE BENEFITS RIDER

This rider amends and is made a part of the policy to which it is attached. It is subject to all provisions, conditions, exclusions and limitations of the policy which are not in conflict with those of this rider.

> Insured means the person covered under the policy to which this rider is attached, requiring Hospice care.
>
> Benefit period means a period of three months during which services are provided on a regular basis.

Page two (2) of the rider reflected:

> If a physician has certified to the Insured's illness, including a prognosis for life expectancy and a statement that Hospice Care is medically necessary, We will pay benefits for Hospice Care Services while this rider is in force. Benefits up to $55.00 per day, but not to exceed $5,000.00 during a Benefit Period will be paid for the following:
>
> 1. Professional nursing and home health aid services provided by or under the supervision of a Registered Nurse (R.N.) or specialized therapist;
> 2. Physical, occupational, speech and audiology, respiratory and inhalation therapy;
> 3. Nutrition counseling related to the Insured's terminal condition;
> 4. Medical social services;
> 5. Family counseling related to the Insured's terminal condition;
> 6. Services of an individual to temporarily relieve the Insured's family or primary care giver for unforeseen emergencies and the daily demands of the Insured's care.
>
> We will pay benefits for the expense incurred by the Insured for medical supplies, … … for short-term inpatient care or continuous home care which may be required during a period of crisis, for pain control or for acute intervention alternatives and chronic symptom management. We will *not pay benefits for such care for more than 30 days during the Insured's lifetime.* [Emphasis added.]

Benefits will be paid for bereavement support services for patient/Family of the deceased Insured during the 3 month period following death, but not exceeding a total of $500.00.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for:

. . .

4. Custodial care.

Rider form HHC(5) 11/85

HOME HEALTH SERVICES

Incomplete

- The rider did not reflect the provision that prior hospitalization is not required in order to receive home health services.
- The provision that "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility, was not reflected.

Page one (1) of the one page rider reflected:

HOME HEALTH CARE BENEFITS

Home Health Care means care and treatment provided by a certified Home Health Agency and designed and supervised by a physician, without which care and treatment a person would require institutionalization in a hospital and consisting of one or more of the following: …

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/08 Stamped: 09/17/08
LB Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1983
Hospice Care Benefits Rider	R-CO (17)	11/85
Home Health Care Benefits	HHC (5)	11/85

Recommendation No. 10:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-8. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the complete and correct extent of coverage to be provided for home health services and hospice care as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant home health and hospice care service benefits and provide the proposed date that the forms will be put in use.

Issue E9: Failure, in some instances, to reflect the mandated benefit coverage for prosthetic devices.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(14) Prosthetic devices.

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance *shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, 13951, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).* [Emphasis added.]

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(c) A health benefit plan may require prior authorization for prosthetic devices in the same manner that prior authorization is required for any other covered benefit.

(d) Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.

(e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.

United's policies CS1, GSP1, GSP2, SHXC, HSXC-C and MMXC did not reflect any prosthetic device benefits.

Form Name	Form Number	Date of Filing
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83

		Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76

Recommendation No. 11:

United shall be provided with a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with it submission or rebuttal, its plan to comply, or documentations showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable policy forms to reflect the mandated coverage benefits for prosthetic devices as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant prosthetic device benefits and provide the proposed date that the forms will be put in use.

Issue E10: Failure, in some instances, to reflect the mandated coverage for early intervention services for an eligible child.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(1.3) Early intervention services.

. . .

(b)(I) *All individual and group sickness and accident insurance policies or contracts issued or renewed by an entity subject to part 2 of this article on or after January 1, 2008, and all service or indemnity contracts issued or renewed by an entity subject to part 3 or 4 of this article on or after January 1, 2008, that include dependent coverage shall provide coverage for early intervention services delivered by a qualified early intervention service provider to an eligible child*. Early intervention services specified in an eligible child's IFSP shall qualify as meeting the standard for medically necessary health care services as used by private health insurance plans. [Emphasis added.]

. . .

(III) Except as provided in paragraph (d) of this subsection (1.3), *the coverage shall not be subject to deductibles or copayments, and any benefits paid under the coverage required by this subsection (1.3) shall not be applied to an annual or lifetime maximum benefit contained in the policy or contract*. … [Emphasis added.]

United was not in compliance with Colorado insurance law in that its policy GSP3 did not provide the mandated early intervention services as follows:

- The benefits to be paid for early intervention services are not to be subject to deductibles and policy GSP3 specifically reflected that all benefits payable shall be subject to the policy deductibles.

- The benefits to be paid for early intervention services are not to be subject to copayments and policy GSP3 specifically reflected that all benefits payable shall be subject to all co-pays of the policy.

- The benefits to be paid for early intervention services shall not be applied to an annual or lifetime maximum benefit contained in the policy or contract and policy GSP3 specifically reflected that all benefits payable shall be subject to dollar-limit provisions of the policy.

Additionally, policies SMXC, CS1, GSP1, GSP2, SHXC, HSXC-C, MMXC, SSXC and GRGSP2C were not in compliance with Colorado insurance law in that they failed to provide the mandated coverage for early intervention services for an eligible child.

Page 12 of the GSP3 policy reflected:

PART 12 OTHER BENEFITS (GSP3)

On the condition that a benefit for expenses incurred for the following care, treatment, services, and supplies is not elsewhere provided in this policy, We will pay benefits for expenses incurred for the following care, treatment, services, and supplies provided to a Covered person while this policy is in force according to the terms, dollar amounts and maximums set forth below in this PART 7 with respect to such covered care, treatment, services, and supplies. *ALL BENEFITS PAYABLE UNDER THIS PART 7 SHALL BE SUBJECT TO ALL POLICY PROVISIONS, LIMITATIONS AND EXCLUSIONS, DEDUCTIBLES, CO-PAYS, CO-INSURANCE, AND DOLLAR-LIMIT PROVISIONS OF THIS POLICY*, EXCEPT AS OTHERWISE SPEECIFICALLY PROVIDED IN THIS PART 7. … [Emphasis added.]

Page 10 of policy GSP3 reflected:

6. EARLY INTERVENTION SERVICES

For treatment or service Early Intervention Services not covered under PARTS 1-10 of this policy, We will pay a sum of money equal to 80% of the incurred charge, not to exceed a maximum benefit of $5,725.00*, including case management costs, for each dependent Eligible Child, who is also a Covered Person, during any one policy year.

*Limit to be adjusted every January 1st by the Colorado Department of Human Services.

United's rider BRO52E1 was not in compliance with Colorado insurance law in that the annual maximum benefit amount reflected for early intervention services was $5,725.00 with no indication that this is the maximum benefit amount established in 2008. The maximum benefit amount for early intervention services was increased to $5,935.00 in 2009 and $6,036.00 in 2010.

Page 2 of Rider BRO52E1 reflected:

. . .

EARLY INTERVENTION SERVICES BENEFIT

We will pay the expenses incurred for a dependent Eligible Child from birth until the child's third birthday for Medically Necessary Early Intervention Services delivered by Qualified Early Intervention Service Provider.

ADDITIONAL LIMITATIONS AND EXCLUSIONS

Coverage for Early Intervention Services is limited to a maximum of $5,725.00, including case management costs, per each dependent Eligible Child per year. Said limit to be adjusted every January 1st by the Colorado department of human services.

Early Intervention Services excludes nonemergency medical transportation, respite care, service coordination, as defined in 34 CFR 303.12(d)(11), and assistive technology.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
Additional Definitions Early Intervention Services Rider	BRO52E1	Actuarial Memorandum is being prepared for filing purposes. Riders have not yet been filed. The benefits department has been notified that the provision is effective and claims should be handled appropriately regardless of whether the form is attached to the policy.
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 12:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect the mandated coverage benefits for early intervention services for an eligible child as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant early intervention services for eligible children and provide the proposed date that the forms will be put in use.

Issue E11: Failure, in some instances, to reflect the mandated coverage of hearing aids for minor children who have a hearing loss or reflecting an exclusion for hearing aids.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(19) Hearing aids for children – legislative declaration.

(a) The general assembly hereby finds and determines that the language development of children with partial or total hearing loss may be impaired due to the hearing loss. Children learn the concept of spoken language through auditory stimuli, and the language skills of children who have hearing loss improve when they are provided with hearing aids and access to visual language upon the discovery of hearing loss. The general assembly therefore declares that providing hearing aids to children with hearing loss will reduce the costs borne by the state, including special education, alternative treatments that would otherwise be necessary if a hearing aid were not provided, and other costs associated with such hearing loss.

(b) *Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, shall provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a physician licensed pursuant to article 36 of title 12, C.R.S., and by an audiologist licensed pursuant to section 12-5.5-102, C.R.S.* The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following: [Emphasis added.]

(I) Initial hearing aids and replacement hearing aids not more frequently than every five years;

(II) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;

(III) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

(c) The benefits accorded pursuant to this subsection (19) shall be subject to the same annual deductible or copayment established for all other covered benefits within the insured's policy and utilization review as provided in sections 10-16-112, 10-16-113, and 10-16-113.5. The benefits shall also be subject to part 7 of this article.

(d) Health benefit plans issued by an entity subject to this part 1 may provide that the benefits required pursuant to this section shall be covered benefits only if the services are deemed medically necessary.

Colorado Insurance Regulation 4-2-30, Concerning The Rules For Complying With Mandated Coverage Of Hearing Aids And Prosthetics, promulgated under the authority of § 10-1-109, C.R.S., states in part:

. . .

Section 3 Applicability

This regulation applies to all individual and group health benefit plans issued or renewed on or after January 1, 2009 by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

Section 4 Definitions

. . .

C. "Hearing aid" shall have the same meaning as set forth in §10-16-102(24.7), C.R.S.

. . .

E. "Minor child" shall have the same meaning as set forth in §10-16-102(27.3),C.R.S.

Section 5 Rules

A. Hearing aids.

1. For the purposes of §10-16-104(19), C.R.S., hearing aids do not meet the traditional definition of durable medical equipment; therefore, *any benefits paid for a minor child's hearing aid(s) in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan's annual or lifetime durable medical equipment maximum, if any*. [Emphasis added.]

2. *The mandated coverage of hearing aids for a minor child shall be provided subject to the same annual deductible and/or copayment/coinsurance levels established for other covered benefits*. Benefits shall be determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). These benefits are subject to the policy's general annual and/or lifetime maximum benefit amounts. Hearing aids are subject to utilization review as provided in §§10-16-112, 10-16-113, and 10-16-113.5, C.R.S. [Emphasis added.]

3. *The coverage includes the initial assessment, fitting, adjustments, and the required auditory training.* Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. This requirement shall

apply to each hearing aid if the minor child has two hearing aids. [Emphasis added.]

United's policies GSP3, CS1, GSP2 and certificate GRGSP2C were not in compliance with Colorado insurance law in that they reflected an exclusion for "hearing aids" which is a mandated coverage for a minor child.

Page 14 of policy GSP3 reflected:

LIMITATIONS AND EXCLUSIONS

PART 13

Except to the extent specifically and directed provided elsewhere in this policy to the contrary, We will not pay benefits under this policy for:

. . .

4. … hearing aids, …

Page 10 of policy CS1 reflected:

PART VI LIMITATIONS AND EXCLUSIONS

. . .

15. No benefits are payable for dental treatments unless due to injury to sound teeth which occurs while the Family Member is insured under the policy; or for temporomandibular joint dysfunction. No benefits are payable for examinations for or *the expense of hearing aids*; [Emphasis added.]

Page 7 of policy GSP2 reflected:

PART 9 LIMITATIONS AND EXCLUSIONS

. . .

5. Dental treatment, *hearing aids,* . . . [Emphasis added.]

Page 8 of the certificate for policy GRGSP2 reflected:

PART 9 LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this Certificate for:

. . .

4. Dental treatment, *hearing aids,* . . . [Emphasis added.]

Policies SMXC, GSP1, SHXC, HSXC-C, MMXC and SSXC were not in compliance with Colorado insurance law in that they did not reflect any information concerning the mandated benefit coverage for hearing aids for children.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/08 Stamped: 09/17/08
LB Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Hospital & Surgical Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 13:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-30. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable policy forms to reflect the required mandated coverage of hearing aids for minor children as required by Colorado insurance law. Within

these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant hearing aid for minor children coverage and provide the proposed date that the forms will be put in use.

Issue E12: Failure, in some instances, to reflect correct or complete required therapy visits for congenital defects and birth abnormalities.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(1.7) Therapies for congenital defects and birth abnormalities.

(a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that *all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday.* [Emphasis added.]

(b) The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or *twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy*. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity. [Emphasis added.]

United's policy GSP3 was not in compliance with Colorado insurance law in that it reflected an incorrect/incomplete description of the medically necessary therapy services for physical, occupational and speech therapy to be provided in the care and treatment of congenital defects and birth abnormalities in the following ways:

Incorrect

- Twenty (20) therapy service visits are to be available for each of the three (3) types of therapy services provided, not limited to a combination of the types of therapy for twenty (20) visits throughout each yearly term.

Incomplete

- Nothing is reflected to indicate that these therapy benefits are to be provided for a covered child from the child's third birthday to the child's sixth birthday.

Page 10 of the policy GSP3 reflected:

. . .

7. **THERAPY SERVICES BENEFIT**

We will provide a benefit for expenses incurred for Medically Necessary Therapy Services for an Eligible Child who is a covered Family Member. Benefits under this subpart of [PART 7] [PART 12] will be provided for therapy visits that are distributed as medically appropriate throughout the yearly term of the policy, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity.

Benefits for Therapy Services covered under this subpart of [PART 7] [PART 12] will be paid as follows:

a. For Therapy Services not covered under [PARTS 1-5] [PARTS 1-10] of this policy because such treatment or service is not being provided in relation to a Sickness, We will consider those Therapy Services as though they were for a covered Sickness under [PART 4] [PART 9] of this policy, but the number of visits shall be limited to the greater of either the number of visits provided under [PART 4] [PART 9] of this policy, or twenty therapy visits per year, each being for physical therapy, occupational therapy, speech therapy, *or any combination thereof.* [Emphasis added.]

b. For Therapy Services not covered under [PARTS 1-5] [PARTS 1-10] of this policy, nor brought within the scope of coverage based on (a) above, We will pay a sum of money equal to 80% of the incurred charge, not to exceed a maximum benefit $50 per periodic visit, up to a maximum of twenty therapy visit provided per Eligible Child during any one policy year, each of those visits being for physical therapy, occupational therapy, speech therapy, *or any combination thereof.* [Emphasis added.]

United policies SMXC, GSP1, GSP2, CS1, HSXC-C, MMXC, SSXC and the certificate for large group policy GRGSP2 were not in compliance with Colorado insurance law in that no coverage is reflected for the mandated benefit coverage to be provided for these therapies. Additionally, policy CS1 reflected exclusions for charges for physical therapy if not performed with the expectation of restoring a family member's level of function. This coverage is to be provided without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

Page 8 of Policy CS1 reflected:

L. LIMITATION OF ELIGIBLE EXPENSES FOR CERTAIN CONDITIONS AND PROCEDURES

. . .

2. Charges for PHYSICAL THERAPY are Eligible Expenses only when performed with the expectation of restoring a Family Member's level of function which has been lost or reduced by injury or illness. Physical therapy performed repetitively to maintain a level of function are not Eligible Expenses. Maintaining a level of function begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

Page 10 of Policy CS1 reflected:

PART VI LIMITATIONS AND EXCLUSIONS

. . .

13. No benefits are payable for charges for physical therapy unless performed with an expectation of restoring a level of function which has been lost or reduced by illness or injury, as described in Part II, L-2. …

Policy SHXC reflected an incomplete description of the benefits to be provided for congenital defects and birth abnormalities.

Page 5 of Policy SHXC reflected:

NEWBORN CHILDREN'S PROVISION

. . .

Coverage for the newborn child shall consist of coverage for Injury or Sickness as provided by this policy including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities (including the care and treatment for cleft lip and/or cleft palate).

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73

		Stamped: 07/23/73
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 14:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to provide written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised the content of all applicable policy forms to reflect complete and correct coverage benefits to be provided for therapy services for congenital defects and birth abnormalities as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant congenital defect and birth abnormalities benefits and provide the proposed date that the forms will be put in use.

Issue E13: Failure, in some instances, to reflect any or a complete description of the mandated minimum coverage to be provided for maternity and newborn hospital stays.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn Children.

. . .

(b)(I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. *If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.*

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. *If ninety-six hours following the cesarean section falls after 8:00 p.m., coverage shall continue until 8 a.m. the following morning*. [Emphases added.]

. . .

(3) Maternity coverage.

. . .

(a)(II) Coverage for a hospital stay following a normal vaginal delivery shall not be limited to less than forty-eight hours. *If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning*.

(III) Coverage for a hospital stay following a cesarean section shall not be limited to less than ninety-six hours. *If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.* [Emphases added.]

The Maternity Benefits, Minimum Hospital Stays rider used by the Company was not in compliance with Colorado insurance law in that it reflected an incomplete description of the mandated minimum hours of coverage to be allowed for in-patient maternity and newborn services by failing to reflect that if the forty-eight or ninety-six hour minimum coverage falls after 8:00 p.m. the in-patient benefits will be covered until 8 a.m. the following morning.

The following is reflected on the one (1) page Rider:

MATERNITY BENEFITS, MINIMUM HOSPITAL STAYS

If the attached policy provides for maternity benefits, We will pay the expenses incurred for a minimum of forty-eight (48) hours of inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care.

> All benefits are subject to any copayment and coinsurance provisions of this policy. This benefit is also subject to any deductibles or dollar limit provisions of the attached policy.

United's policies HIXC, HMXC and CS1 were not in compliance with Colorado insurance law in that they reflected an incomplete description of the mandated minimum hours of coverage to be allowed for *in-patient maternity* and *newborn services* and fail to reflect that if the forty-eight or ninety-six hour minimum coverage falls after 8:00 p.m. the in-patient benefits will be covered until 8 a.m. the following morning.

Page 2 of the Policy HIXC reflected:

> PART 7 ADDITIONAL BENEFITS FOR PREGNANCY
>
> If a Family Member shall be confined within a hospital as a resident patient as a result of pregnancy (including childbirth or complications arising therefrom) after ten months from the date hereof and if benefits for such confinement are payable under Part 1 of this policy, the Company will pay additional benefits beginning with the first full day of such confinement, at the rate of the Daily Hospital Indemnity Benefit specified in Schedule A for each day of such confinement, but not to exceed 3 days for any one pregnancy.

Policies GSP1, SHXC, HSXC-C, MMXC and SSXC were not in compliance with Colorado insurance law in that they did not reflect any information concerning the mandated minimum hours of hospital stay coverage to be allowed for in-patient maternity and newborn services.

Form Name	Form Number	Date of Filing
Newborns' and Mothers' Health Protection Rider	NMHPA	Submitted: 07/30/03 Stamped: 08/27/03
Hospital Indemnity	HIXC	Resubmitted: 05/24/76 Stamped: 05/26/76
Hospital Indemnity	HMXC	Submitted: 09/14/79 Stamped: 09/18/79
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76

LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73

Recommendation No. 15:

United shall be provided as reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable policy forms to reflect the complete benefits to be provided for maternity and newborn hospital stays as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant maternity benefits and provide the proposed date that the forms will be put in use.

Issue E14: Failure, in some instances, to allow benefits for any loss incurred while an insured is engaged in the military, naval or air services of any country.

Section 10-16-104, Mandatory coverage provisions – definitions, states in part:

. . .

(16)(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall not refuse to provide coverage to an individual, refuse to continue to cover an individual, *or limit the amount or extent of coverage available to an individual solely based on that individual's membership in the uniformed services of the United States*. Nothing in this subsection (16) shall prohibit an insurer from excluding or limiting coverage for some other factor or preexisting condition. [Emphases added.]

(b) As used in this subsection (16):

(I) "Membership" means active duty, national guard, or reserve duty in the uniformed services of the United States, or retirement from such services.

(II) "Uniformed services of the United States" means the United States Army, United States Navy, United States Marine Corps, United States Air Force, United States Coast Guard, national oceanic and atmospheric administration commissioned officer corps, and the United States public health service commissioned corps.

United's accident rider R-ACC2 was not in compliance with Colorado insurance law in that it excluded benefits for any loss while an insured is engaged in the military or naval service of any country.

Page 3 of the Rider reflected:

PART 5 LIMITATIONS AND EXCLUSIONS

This rider does not cover accidents injury, death, disability or other loss caused:

. . .

2. *while engaged in military or naval service of any country*, or as a result of war or any act of war, and any premium paid to the Company for any period not covered by reason of the Covered Person's military or naval service, will be returned, upon notice, pro rata, to the Insured. [Emphasis added.]

The Company's certificate for policy GRGSP2 was not in compliance with Colorado insurance law in that it excluded the accidental death benefit provided by the plan if caused by service in the military, naval or air services of any country. The amount or extent of coverage available to an individual cannot be limited based on that individual's membership in the uniformed services of the United States. Membership is defined as active duty, national guard, or reserve duty in the uniformed services of the United States or retirement from such services.

Page 8 of the Certificate reflected:

> **PART 9 LIMITATIONS AND EXCLUSIONS**
>
> **IN ADDITION, THIS POLICY DOES NOT COVER DEATH CAUSED BY:**
>
> . . .
>
> 4. Service in the military, naval or air services of any country

Policy UA-250 was not in compliance with Colorado insurance law in that it excluded benefits for any loss caused while an insured is engaged in the military or naval service of any country.

Page 4 of the Policy reflected:

> PART 6 LIMITATIONS AND EXCLUSIONS
>
> This policy does not cover accidents, injury, death, disability or other loss caused:
>
> . . .
>
> 2. *while engaged in military or naval service of any country*, or as a result of war or any act of war, and any premium paid to the Company for any period not covered by reason of the Covered Person's military or naval service, will be returned, upon notice, pro rata, to the Insured. [Emphasis added.]

Form Name	Form Number	Date of Filing
Accident Rider	R-ACC2	Submitted: 11/15/04 Stamped: 12/07/04
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.
Accident Expense Policy	UA-250	Submitted: 08/04/93 Stamped: 06/07/94

Recommendation No. 16:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised the content of all applicable policy forms to indicate that the amount or extent of coverage available to an individual is not limited based on that individual's

membership in the uniformed services of the United States as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant coverage eligibility and provide the proposed date that the forms will be put in use.

Issue E15: Failure, in some instances, to reflect the required definition of complications of pregnancy or to reflect that this is a mandated coverage to be provided for as any other similar sickness or disease is otherwise covered under the policy or certificate of insurance.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(2) Complications of pregnancy and childbirth.

(a) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article and any individual or group service or indemnity contract issued by an entity subject to part 3 of this article *shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy or contract.* Any sickness and accident insurance policy providing indemnity for disability due to accident shall provide coverage for an accident which occurs during the course of pregnancy or childbirth in the same manner as any other similar accident is covered under the policy. [Emphasis added.]

(b) *Any sickness and accident insurance policy providing coverage for sickness on an expense-incurred basis shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy*. [Emphasis added.]

Colorado Insurance Regulation 4-2-6, Concerning the Definition of the Term "Complications of Pregnancy" for use in Accident and Health Insurance Policies, promulgated under the authority of §§ 10-1-109, 10-16-109 and 10-3-1110, C.R.S., states in part:

. . .

Section 2. Purpose

The purpose of this regulation is to standardize the definition of the term "complications of pregnancy" as employed in sickness and accident insurance policies covering residents of this state consistent with the commonly perceived connotation of this term by the general public.

. . .

Section 4. Definitions

For the purposes of this regulation "Complications of pregnancy" shall mean:

(1) Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;

(2) Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Section 5. Rules

All insurers marketing sickness and accident insurance policies, as defined in this regulation, delivered or issued for delivery in the State of Colorado *shall employ in each insurance policy or certificate of insurance a definition of the complications of pregnancy no more restrictive than that required by this regulation.* [Emphases added.]

Policies SMXC, GSP1, GSP2 and the certificate for policy GRGSP2 were not in compliance with Colorado insurance law as they did not include the required definition of the term "Complications of Pregnancy." Additionally, there was nothing reflecting that this is a mandatory coverage to be provided in the same manner as any other similar sickness or disease is covered under the policy.

Page 5 of policy SMXC reflected;

PART 7 BENEFITS FOR NORMAL PREGNANCY

We will pay benefits for Hospital expenses incurred by You or a Family Member for a Hospital Stay that is due to normal pregnancy (including childbirth), but not to exceed the Maternity Benefit shown in the Benefit Schedule for any one normal pregnancy (including childbirth).

Form Name	Form Number	Date of Filing
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 17:

United shall be afforded a reasonable period, not exceeding thirty (30) days from the date this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-6. In the event United is unable to show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect a compliant definition of complications of pregnancy and to indicate that this is a mandated coverage as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing a compliant definition of complications of pregnancy and provide the proposed date that the forms will be put in use.

Issue E16: Failure, in some instances, to define correctly or completely the requirements for a person to qualify as a dependent.

Section 10-16-102, C.R.S., Definitions, states in part:

. . .

(14) "Dependent" means a spouse, an unmarried child under nineteen years of age, *an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent*. … [Emphasis added.]

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(6.5) Adopted child – dependent coverage.

(a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, the entity shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber, *regardless of whether adoption of the child is final*. [Emphasis added.]

. . .

(c) For the purposes of this subsection (6.5), unless the context otherwise requires:

. . .

(II) *"Placed for adoption" means circumstances under which a person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption*. A placement terminates at the time such legal obligation terminates. [Emphasis added.]

Section 10-16-104.3, C.R.S., Dependent health coverage for persons under twenty-five years of age – coverage for students who take medical leave of absence, states in part:

(1) All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article and all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that offer dependent coverage *shall offer to the parent, for an additional premium if applicable, by rider or supplemental policy provision, the same dependent coverage for an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102 if such child*:

(a) Has the same legal residence as the parent; or

(b) Is financially dependent upon the parent. [Emphases added.]

(3)(a) All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article and all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that provide dependent coverage to a child who is enrolled in a postsecondary educational institution shall not terminate coverage due to a medically necessary leave of absence before the date that is the earlier of:

(I) One year after the first day of the medically necessary leave of absence; or

(II) The date the coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(b) For purposes of this subsection (3), "medically necessary leave of absence" means a leave of absence from a postsecondary educational institution or a change in enrollment of the dependent at the institution that:

(I) Begins while the dependent is suffering from a serious illness;

(II) Is medically necessary; and

(III) Causes the dependent to lose student status for the purpose of dependent coverage.

United's policies GSP3, SMXC, MMGAP, SHXC, HSXC-C, MMXC and SSXC, were not in compliance with Colorado insurance law in that the definition of who may qualify as a "dependent" was incomplete or incorrect in the following ways:

Incomplete

- Nothing was reflected to indicate that an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child of any age who is medically certified as disabled and dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102, has the same legal residence as the parent and is financially dependent on the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that coverage as a dependent is to be available for an adopted child when the child is "placed for adoption", regardless of whether adoption of the child is final.

Incorrect

- Policy SHXC in addition to having an incomplete description of who may qualify as a dependent was incorrect in reflecting that coverage shall terminate on the first policy anniversary date after the child attains age 23. A dependent in "student status" that loses it because of a medically necessary leave of absence, may not have coverage automatically terminated on the first policy anniversary date after attaining age 23.

Page 2 of policy GSP3 and Page 2 of the SMXC policy reflected:

> **FAMILY MEMBER** means a person who is named in the application for coverage under this policy, [for this policy] other than the Proposed Insured, or a person who has been added in accordance with the ELIGIBILITY AND INSURED'S TERMINATION provision.

Page 15 of policy GSP3 and Page 6 of policy SMXC reflected:

POLICY PROVISIONS

> **ELIGIBILITY AND INSURED'S TERMINATION:** You, as the Insured, are the beneficiary of Your covered Family Members. Every transaction relating to this policy shall be between Us and You.
>
> A new Family Member (including husband, wife any children under the age of 19 years or any other person dependent upon You or any other person related to and resident in Your household) may be added to this policy. You must make written application for the new member and, except for a child of Yours born or adopted after the effective date of this policy, furnish evidence of eligibility and insurability satisfactory to Us. You must also pay the required additional premium for the new member. Acceptance of the new member shall be shown by an endorsement attached to the policy. The date of the endorsement shall be deemed the effective date of the policy with respect to the new member.

Page 2 of policy GSP2 reflected:

> **DEFINITIONS**
>
> Where used in this policy:
>
> **FAMILY MEMBER** means a person who is named in the application for this policy or has been added in accordance with the ELIGIBILITY AND INSURED'S TERMINATION provision.

Page 8 policy GSP2 reflected:

> **POLICY PROVISIONS**
>
> **ELIGIBILITY AND INSURED'S TERMINATION:** You, as the insured, are the beneficiary of Your Family Members. Every transaction relating to this policy shall be between Us and You.

A new Family Member (including husband, wife, any children under the age of nineteen years or any other person dependent upon You or any other person related to and resident in Your household) may be added to this policy. You must make written application for the new member and furnish evidence of eligibility and insurability satisfactory to Us. You must also pay the required additional premiums for the new member. Acceptance of the new member shall be shown by an endorsement attached to the policy. The date of the endorsement shall be the effective date of the policy with respect to the new member.

A child of Yours born or adopted after the effective date of this policy will be covered as a Family Member from and after the moment of birth or adoption providing: (1) You make application within 45 days after birth or adoption; and (2) You pay the required additional premium within 30 days after You are notified of the amount. Any waiting period applicable to eligibility of a Family Member is deleted with respect to the child.

Page 4 of policy MMGAP reflected:

POLICY PROVISIONS

ELIGIBILITY AND NSURED'S TERMINATION

A Child of Yours born or adopted after the Effective Date of this policy will be covered as a Family Member from and after the moment of birth or adoption providing: (1) You make application within 45 days after birth or adoption; and (2) You pay the required additional premium within 30 days after You are notified of the amount. Any waiting period applicable to eligibility of a Family Member is deleted with respect to the child.

Page 1 of policy SHXC reflected:

RENEWAL AGREEMENT

Coverage for each of Your children who is a Family Member shall terminate on the first policy anniversary date after the child attains age 23. Termination of coverage will not affect any existing claim.

Page 6 of policy SHXC reflected:

POLICY PROVISIONS

A new Family Member, (including husband, wife, and children under the age of nineteen years) may be added to this policy. . . .

Page 7 of policy HSXC-C reflected:

POLICY PROVISIONS
ELIGIBILITY AND INSURED'S TERMINATION:

> A new Family Member, (including husband, wife, any children under the age of nineteen years or any other person dependent upon You or any other person related to and resident in Your household) may be added to this policy. . . .

Page 3 (pages not numbered) of policy MMXC reflected:

> POLICY PROVISIONS
>
> OWNERSHIP: CONTROL OF POLICY:
>
> . . . Additional new members, including husband, wife, dependent children or any children under the age of nineteen years or any other person dependent upon the Insured or any other person related to and resident in the household of the Insured, may be added to this policy from time to time by the Insured upon written application therefor, with evidence of eligibility and insurability satisfactory to the Company, and upon payment of the required premiums for such additional new members.

Page 3 (pages not numbered) of policy SSXC reflected:

> . . . Additional new members, including husband, wife, dependent children or any children under the age of nineteen years or any other person dependent upon the Insured or any other person related to and resident in the household of the Insured, may be added to this policy from time to time by the Insured upon written application therefor, with evidence of eligibility and insurability satisfactory to the Company, and upon payment of the required premiums for such additional new members.

The certificate for policy GRGSP2 was not in compliance with Colorado insurance law in that the definition of who may qualify as a "dependent" was incorrect or incomplete in the following ways:

Incorrect

- The policy reflected that coverage shall terminate for an unmarried family member child at age twenty-three (23) if the child is a full-time student. The definition of a dependent includes a full-time student financially dependent upon the parent and under age twenty-four (24).

- An incorrect upper age limit of nineteen (19) years is reflected for any children to be added to the policy.

Incomplete

- Nothing was reflected to indicate that dependent coverage is to be offered to an unmarried child who is under twenty-five (25) years of age, and is not a dependent as defined by section 10-16-102, has the same legal residence as the parent and is financially dependent on the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child of any age who is medically certified as disabled and dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that coverage as a dependent is to be available for an adopted child when the child is "placed for adoption", regardless of whether adoption of the child is final.

Page 2 of certificate GRGSP2C reflected:

> ELIGIBILITY AND CONVERSION RIGHTS
>
> . . . Coverage for each of Your children who is a Family Member shall terminate on the first Certificate anniversary after the child attains age 19, or marries, whichever occurs first (or age 23 if child is a full-time student in a vocational-technical school, college, or university).

Page 8 of certificate GRGSP2C reflected:

> CERTIFICATE PROVISIONS
>
> A new Family Member, (including husband, wife, any children under the age of nineteen years or any other person under the age of nineteen years dependent upon You and resident in Your household) may be added to this Certificate. You must make written application for the new member and furnish evidence of eligibility and insurability satisfactory to Us. You must also pay the required additional premiums for the new member. Acceptance of the new member shall be shown by an endorsement attached to the Certificate. The date of the endorsement shall be the effective date of the Certificate with respect to the new member. A child of Yours born or adopted after the effective date of this Certificate will be covered as a Family Member from and after the moment of birth or adoption providing: . . .

The policies identified below were not in compliance with Colorado insurance law in that the definition of who may qualify as a dependent was incorrect or incomplete in the following ways:

Policy CANLS-2

- An incorrect upper age limit of twenty-three (23) years was indicated for a full-time student. An unmarried child who is a full-time student under twenty-four (24) years of age and who is financially dependent upon the parent can be considered a dependent for purposes of coverage.

- An incorrect statement concerning coverage for adopted children was reflected. Coverage as a dependent is to be available for an adopted child when the child is "placed for adoption", regardless of whether adoption of the child is final.

- An incorrect termination provision was reflected that states dependent coverage will terminate on the policy anniversary date following their 21st birthday unless they are a full-time student under age 23. A dependent who is enrolled in a postsecondary educational institution shall not have their coverage terminated due to a medically necessary leave of absence before the earlier of (1) one year after the first day of the medically necessary leave of absence or (2) the date the coverage would otherwise terminate under the terms of the plan or health insurance coverage.

- The definition of who may qualify as a dependent was incomplete as nothing is reflected to indicate that dependent coverage is to be offered to an unmarried child who is under twenty-five (25) years of age, and is not a dependent as defined by section 10-16-102, has the same legal residence as the parent and is financially dependent on the parent can be considered a dependent for purposes of coverage.

Page 2 of policy CANLS-2 reflected:

> DEFINITIONS
>
> COVERED FAMILY MEMBER: The spouse of the Insured and all unmarried children of the Insured, under age 19, on the Policy Date. To be covered, each existing member must be named in the application. Any member who has had Cancer diagnosed is excluded from coverage. Stepchildren and legally adopted children can be included if listed in the application. Children born after the Policy Date are automatically covered for 31 days. If you notify us of their birth and pay the required premium within that time, their coverage will continue. You may apply for coverage on other dependents acquired after the Policy Date, subject to our approval. Coverage on your children terminates when they marry. It also terminates on the policy anniversary date following their 21st birthday, unless they are still dependent on you due to a physical or mental handicap, or because they are a full-time student under age 23. You must furnish us proof of the handicap or student status within 31 days of the termination date.

Policy CAGR

- An incorrect statement concerning coverage for adopted children was reflected. Coverage as a dependent is to be available for an adopted child when the child is "placed for adoption", regardless of whether adoption of the child is final.

- An incorrect limitation was reflected that requires a child to have become disabled prior to the first policy anniversary following the child's 25th birthday, to continue to be a "Covered Person". An unmarried child of any age who is medically certified as disabled and dependent upon the parent falls within the definition of a dependent for purposes of coverage.

Page 2 of policy CAGR reflected:

> DEFINITIONS
>
> If this is a "Family" policy, the terms "You", "Your", "Covered Person" and "Covered Adult" mean the Primary Insured and the Spouse of the Primary Insured, both listed in the Policy Schedule. Any child who is unmarried, is under 25 years of age, and is dependent on the Primary Insured is a "Covered Person" is such child is listed in the Policy Schedule. In no event is a child a "Covered Adult" except as provided in the provision entitled "Eligibility and Insured's Termination."
>
> Any newborn or newly adopted children of the Primary Insured will automatically (sic) be a "Covered Person" from the moment of birth or adoption if such birth or adoption occurs after the "Effective Date" of the policy.
>
> If this is an "Individual" policy, newborn or newly adopted children of the Primary Insured are covered from the moment of birth or adoption; however, You must notify the Company within 60 days after the birth or adoption of Your child so that We can (a) add Your child to the policy by endorsement, and (b) change Your policy to "Family" policy and arrange for the payment of the appropriate "Family" premium.

> The insurance on any child shall terminate on the first policy anniversary date following either (a) the child's 25th birthday or (b) the child's marriage. However, if a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 25th birthday, then the child will continue to be a "Covered Person" for as long as such disability continues. Proof of such incapacity or disability must be furnished upon Our request, but not more often than annually.

Policy CAXC

- An incorrect upper age limit of nineteen (19) years was reflected for any children to be added to the policy.

- Nothing was reflected to indicate that an unmarried child who is a full-time student under twenty-four (24) years of age and who is financially dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child of any age who is medically certified as disabled and dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102, has the same legal residence as the parent and is financially dependent on the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that coverage as a dependent is to be available for an adopted child when the child is "placed for adoption", regardless of whether adoption of the child is final.

Page 2 of policy CAXC reflected:

> POLICY PROVISIONS
>
> ELIGIBILITY AND INSURED'S TERMINATION:
>
> . . .
>
> A new Family Member, (including husband, wife, any children under the age of nineteen years or any other person dependent upon You or any other person related to and resident in Your household) may be added to this policy. You must make written application for the new member and furnish evidence of eligibility and insurability satisfactory to Us. You must also pay the required additional premiums for the new member. Acceptance of the new member shall be shown by an endorsement attached to the policy. The date of the endorsement shall be the effective date of the policy with respect to the new member.

Policy CIXC

- An incorrect upper age limit of nineteen (19) years was reflected for any children to be added to the policy.

- Nothing was reflected to indicate that an unmarried child who is a full-time student under twenty-four (24) years of age and who is financially dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child of any age who is medically certified as disabled and dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102, has the same legal residence as the parent and is financially dependent on the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that coverage as a dependent is to be available for an adopted child when the child is "placed for adoption", regardless of whether adoption of the child is final.

Page 2 of policy CIXC reflected:

> POLICY PROVISIONS
> ELIGIBILITY AND INSURED'S TERMINATION:
>
> . . .
>
> A new Family Member, (including husband, wife, any children under the age of nineteen years or any other person dependent upon You or any other person related to and resident in Your household) may be added to this policy. You must make written application for the new member and furnish evidence of eligibility and insurability satisfactory to Us. You must also pay the required additional premiums for the new member. Acceptance of the new member shall be shown by an endorsement attached to the policy. The date of the endorsement shall be the effective date of the policy with respect to the new member.

The Company's certificate for policy GRGSP2 was not in compliance with Colorado insurance law in that the definition of who may qualify as a "dependent" was incorrect or incomplete in the following ways:

<u>Incorrect</u>

- The policy reflected that coverage shall terminate for an unmarried family member child at age twenty-three (23) if the child is a full-time student. The definition of a dependent includes a full-time student financially dependent upon the parent and under age twenty-four (24).

- An incorrect upper age limit of nineteen (19) years is reflected for any children to be added to the policy.

<u>Incomplete</u>

- Nothing was reflected to indicate that dependent coverage is to be offered to an unmarried child who is under twenty-five (25) years of age, and is not a dependent as defined by section 10-16-102, has the same legal residence as the parent and is financially dependent on the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child of any age who is medically certified as disabled and dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that coverage as a dependent is to be available for an adopted child when the child is "placed for adoption", regardless of whether adoption of the child is final.

Page 2 of certificate GRGSP2C reflected:

> ELIGIBILITY AND CONVERSION RIGHTS
>
> . . . Coverage for each of Your children who is a Family Member shall terminate on the first Certificate anniversary after the child attains age 19, or marries, whichever occurs first (or age 23 if child is a full-time student in a vocational-technical school, college, or university).

Page 8 of certificate GRGSP2C reflected:

> CERTIFICATE PROVISIONS
>
> A new Family Member, (including husband, wife, any children under the age of nineteen years or any other person under the age of nineteen years dependent upon You and resident in Your household) may be added to this Certificate. You must make written application for the new member and furnish evidence of eligibility and insurability satisfactory to Us. You must also pay the required additional premiums for the new member. Acceptance of the new member shall be shown by an endorsement attached to the Certificate. The date of the endorsement shall be the effective date of the Certificate with respect to the new member. A child of Yours born or adopted after the effective date of this Certificate will be covered as a Family Member from and after the moment of birth or adoption providing: . . .

United's policy UA-250 was not in compliance with Colorado insurance law in that the definition of who may qualify as a "dependent" was incorrect and incomplete in the following ways:

<u>Incorrect</u>

- An incorrect upper age limit of nineteen (19) years was reflected for any unmarried dependent children of the insured to be eligible for coverage.

<u>Incomplete</u>

- Nothing was reflected to indicate that dependent coverage is to be offered to an unmarried child who is under twenty-five (25) years of age, and is not a dependent as defined by section 10-16-102, has the same legal residence as the parent and is financially dependent on the parent can be considered a dependent for purposes of coverage.

- Nothing was reflected to indicate that an unmarried child of any age who is medically certified as disabled and dependent upon the parent can be considered a dependent for purposes of coverage.

- Nothing is reflected to indicate that coverage as a dependent is to be available for an adopted child when the child is "placed for adoption", regardless of whether adoption of the child is final.

- Nothing was reflected to indicate that an unmarried child who is a full-time student under twenty-four (24) years of age and who is financially dependent upon the parent can be considered a dependent for purposes of coverage.

Additionally, the Company was not in compliance with Colorado insurance law in that it does not have a mechanism in place to offer dependent coverage for an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102, if the child has the same legal residence as the parent or is financially dependent upon the parent. This offer is to be made either by rider or supplemental policy provision.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital Surgical Expense	MMGAP	Submitted: 09/17/2007 Stamped: 10/10/2007
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Cancer Policy (1st Diagnosis Benefit)	CANLS-2	Submitted Date: 10/10/05 Stamped Date: 12/05/05
Cancer Policy (Hospital Confinement)	CAGR	Submitted Date: 04/19/90 Stamped Date: 09/24/90
Cancer Policy (Expense & Indemnity)	CAXC	Submitted Date: 07/25/80 Stamped Date: 07/28/80
Cancer Policy (Indemnity)	CIXC	Submitted Date: 07/28/80 Stamped Date: 08/27/80
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05 Never filed in Colorado.

Accident Expense Policy	UA-250	Submission: 08/04/93 Stamped: 06/07/94

Recommendation No. 18:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-16-102, 10-16-104 and 10-16-104.3, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable policy forms to reflect a complete and correct definition of who qualifies as a dependent and its procedures to ensure that coverage is offered to all eligible persons as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing a compliant definition of a dependent. Additionally, the Company shall provide evidence of having in place the procedures to offer dependent coverage for an unmarried child who is under twenty-five years of age, and is not a dependent as defined by § 10-16-102, C.R.S.

Issue E17: Failure, in some instances, to reflect any information about the effect creditable coverage would have on any preexisting period.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

. . .

(1)(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule.

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority of §§ 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

. . .

Section 5. Rules

. . .

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation *shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.* [Emphasis added.]

2. *Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage*, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations. [Emphasis added.]

United's policies GSP3, SMXC, HIXC, HMXC, CS1, GSP1, GSP2, SHXC, HSXC-C, MMXC and SSXC and certificates GRGSP2C, TRHPC and ERHPC-CO were not in compliance with Colorado insurance law in that there is no information reflected about the effect creditable coverage would have on any preexisting period.

Page 2 of the GSP3 policy reflected:

PRE-EXISTING CONDITION LIMITATION

This policy does not insure You against loss incurred by You or a covered Family Member during the 12 months immediately after the effective date of this policy if that loss results from a Pre-Existing Condition. In addition, any Pre-Existing Condition listed on the application is not covered for the first 12 months after the policy effective date. Conditions, illnesses, diseases, disorders, or injuries specifically excluded by rider are never covered.

Page 1 (pages not numbered) of policy HIXC, reflected:

The Insuring Clause

HEREBY INSURES the Applicant, first named in the following Schedule A, hereinafter called the Insured, and all dependent members of the Insured's family, if any, named in the application for this policy (all of whom including the Insured are hereinafter called Family Members), a copy of which is attached hereto and made a part hereof, against loss, subject to all provisions and limitations (HIXC Policy Form: "subject to all provisions, limitations and exclusions") herein contained and will pay the benefits provided herein for medical treatment and other specified expense incurred beginning while this policy is in force

. . .

b) resulting from sickness first manifesting itself while this policy is in effect and after the effective date hereof, hereinafter referred to as such sickness;

Page 2 (pages not numbered) of policy HMXC reflected:

LIMITATIONS AND EXCLUSIONS

PART 3

. . .

4. Loss resulting from injury sustained or sickness first manifesting itself prior to the effective date of this policy is not covered unless incurred more than 120 days after the effective date.

Page 3 of policy CS1 and page 2 of policy GSP1 and policy GSP2 reflected:

PRE-EXISTING CONDITION LIMITATION

This policy does not insure You against loss incurred during the twelve (12) months immediately after the effective date of this policy if that loss results from a Pre-Existing Condition. In addition, any Pre-Existing Condition listed on the application is not covered for the first twelve (12) months after the policy effective date.

Page 2 of policy SHXC reflected:

> THE INSURING CLAUSE
>
> The Company insures You against loss incurred by a Family Member as a result of (a) a Sickness or an Injury occurring after this policy is in effect, and (b) a Pre-Existing Sickness occurring after this policy is in effect for six months. The Company does not insure You against loss resulting from a Pre-Existing Sickness occurring during the six months immediately after the effective date of this policy.

Page 1 (pages not numbered) of policies MMXC and SSXC reflected:

> The Insuring Clause
>
> . . . and will pay the benefits provided herein for hospital confinement and other specified expense incurred beginning while this policy is in force (Form MMXC)
>
> . . . and will pay the benefits provided herein for surgical treatment and other specified expense incurred beginning while this policy is in force (Form SSXC)
>
> (a) Resulting from accidental bodily injury sustained while this policy is in effect, hereinafter referred to as such injury; and
>
> (b) Resulting from sickness first manifesting itself while this policy is in effect and after the effective date hereof, hereinafter referred to as such sickness;

Page 2 of the Certificate for policy GRGSP2 reflected:

> **INSURING CLAUSE**
>
> The Company insures You against specified losses incurred by You or a Family Member. Benefits stated in this Certificate, subject to all its provisions, limitations and exclusions, will be paid for such losses *which are incurred while this Certificate is in force*. [Emphasis added.]
>
> **[PRE-EXISTING CONDITION LIMITATION**
>
> This Certificate does not insure You against loss incurred during the [twelve (12)] months immediately after the effective date of this Certificate if that loss results from a Pre-Existing Condition. In addition, any Pre-Existing Condition listed on the application is not covered for the first [twelve (12)] months after the Certificate effective date.]

Page 2 of certificates TRHPC and ERHPC reflect:

> PRE-EXISTING CONDITIONS LIMITATIONS PROVISION
>
> Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the Certificate effective date.

There is nothing reflected in the SMXC or the HSXC-C policies concerning Pre-Existing Condition Limitations.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Hospital Indemnity	HIXC	Resubmitted: 05/24/76 Stamped: 05/26/76
Hospital Indemnity	HMXC	Submitted: 09/14/79 Stamped: 09/18/79
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.
Teamsters Retiree Health Plan Certificate (Large Group)	TRHPC	Submitted: 08/14/96 Stamped: 08/22/96
Employer Retirement Health Plan Certificate (Large Group)	ERHPC-CO	Submitted: 07/08/97 Stamped: 07/17/97

Recommendation No. 19:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado Insurance Regulation 4-2-18. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable policy forms to reflect the correct definition of creditable coverage and preexisting coverage as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant definitions of creditable coverage and preexisting coverage and provide the proposed date that the forms will be put in use.

Issue E18: Failure, in some instances, to reflect correct benefits or to reflect any benefits for treatment and services to be provided to newborn children born with cleft lip or cleft palate.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(1)(c)(II)(A) With regard to newborn children born with cleft lip or cleft palate or both, *there shall be no age limit on benefits for such conditions, and care and treatment shall include to the extent medically necessary*: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment. [Emphasis added.]

(B) Cleft lip, cleft palate, or any condition or illness which is related to or developed as a result of the cleft lip or cleft palate shall be considered to be compensable for coverage under the provisions of sub-subparagraph (A) of this subparagraph (II).

United policy GSP3 was not in compliance with Colorado insurance law in that it reflected an age limit of under the age of eighteen (18) years for treatment. There is no age limit on the provision of benefits for such conditions.

Additionally, the policy reflected a maximum benefit of $500.00 for all treatment and services provided to or for any one covered person for cleft lip and/or cleft palate. Colorado insurance law does not indicate that a maximum benefit may be used on benefits for these conditions, only that care and treatment shall be included to the extent medically necessary.

Page 4 of the GSP3 (numeric listing) policy reflected:

DEFINITIONS

MEDICALLY NECESSARY CARE AND TREATMENT (for Cleft Lip and Cleft Palate Benefit) includes:

a) [1] oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons;
b) [2] prosthetic treatment such as obturators, speech appliances, and feeding appliances;
c) [3] Medically Necessary orthodontic treatment;
d) [4] Medically Necessary prosthodontic treatment;
e) [5] habilitative speech therapy;
f) [6] otolaryngology treatment; and
g) [7] audiological assessments and treatment.

Page 11 of policy GSP3 (Part 12) reflected:

OTHER BENEFITS

. . .

9. **CLEFT LIP AND CLEFT PALATE**

We will provide a benefit for expenses incurred by or for a Covered Person for treatment of cleft lip, cleft palate, or both, provided to a Covered Person *who, at the time of the treatment, is under the age of eighteen (18) years*. We will cover medical, dental, speech therapy, audiology, nutrition services, or any combination thereof provided by appropriately licensed professionals that are prescribed by the treating Physician, who is a medical doctor or doctor of osteopathy, who certifies in writing that the service is Medically Necessary for and consequent to treatment of that Covered Person's cleft lip, cleft palate, or both. [Emphasis added.]

A benefit for cleft lip and cleft palate treatment and services covered under this subpart of PART 7 [PART 12] will be paid as follows:

a. For treatment and services for cleft lip or cleft palate not covered under PARTS 1-5 [PARTS 1-10] of this policy because such treatment and services are not being provided in relation to a Sickness, We will consider that Covered Person's treatment and services for cleft lip or cleft palate as though they were for a Sickness under this policy.

b. For treatment and service for cleft lip or cleft palate not covered under PARTS 1-5 [PARTS 1-10] of this policy, nor brought within the scope of coverage based on (a) above, We will pay a sum equal to 80% of the incurred expenses, *not to exceed a maximum benefit of $500.00 for all such treatment and services provided to or for any one Covered Person for cleft lip and cleft palate*. [Emphasis added.]

Policy SHXC was not in compliance with Colorado insurance law in that it reflected an incomplete description of the coverage provisions for the mandated benefit of treatment and service for cleft lip or cleft palate or both.

Page 5 of policy SHXC reflected:

PART 7 NEWBORN CHILDREN'S PROVISION

. . .

Coverage to the newborn child shall consist of coverage for Injury or Sickness as provided by this policy including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities (including the care and treatment for cleft lip and/or cleft palate.)

Policies SMXC, HIXC, HMXC, CS1, GSP1, GSP2, MMGAP, HSXC-C, MMXC, SSXC and GRGSP2C reflected nothing concerning the mandated benefit of treatment and service for cleft lip or cleft palate or both.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Hospital Indemnity	HIXC	Resubmitted: 05/24/76 Stamped: 05/26/76
Hospital Indemnity	HMXC	Submitted: 09/14/79 Stamped: 09/18/79
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	MMGAP	Submitted: 09/17/07 Stamped: 10/10/07
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 20:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event that United is unable to provide such documentation, the Company may submit with its submission or rebuttal, its plan to comply, or documentation that it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable policy forms to reflect the correct coverage to be provided for newborn children born with cleft lip, cleft palate, or both as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant cleft lip/palate coverage benefits and provide the proposed date that the forms will be put in use.

Issue E19: Failure, in some instances, to reflect correct and complete required provisions in individual and group policies.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section10-16-204, each such policy delivered or issued for delivery to any person in this state *shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary*. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

. . .

(5) (a) A provision as follows: "Reinstatement: … Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, *but not to any period more than sixty days prior to the date of reinstatement."*

. . .

(8) A provision as follows: "Proofs of loss: *Written proof of loss must be furnished* to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss *within ninety days* after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, if such proof is furnished as soon as reasonably possible and in no event, *except in the absence of legal capacity, later than one year from the time proof is otherwise required."*

. . .

(12) A provision as follows: "Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought *after the expiration of three years after the time written proof of loss is required to be furnished."*

(13)(a) A provision as follows: *"Change of beneficiary*: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy." [Emphases added.]

Section 10-16-214, C.R.S., Group sickness and accident insurance, states in part:

> . . .
>
> (3) (a) Except as provided for in subsection (2) of this section, *all policies of group sickness and accident insurance* providing coverage to persons residing in the state *shall contain in substance the following provisions or provisions* which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder: [Emphases added.]
>
> . . .
>
> (V1) A provision specifying the ages, if any, to which the insurance provided is limited, the ages, if any, for which additional restrictions are placed on benefits, and the additional restrictions placed on the benefits at such ages. If the premiums or benefits vary by age, *there shall also be a provision specifying* an equitable adjustment of premiums or benefits, or both, to be made *in the event the age of a covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used.* . . . [Emphases added.]

United's policies GSP3 and SMXC were not in compliance with Colorado insurance law in that they failed to reflect correct and complete provisions required in individual policies in the following ways:

Incorrect

- The required provision concerning when "proof of loss" must be submitted in the absence of legal capacity is more restrictive than the time period of fifteen months allowed by Colorado insurance. The provision of one year for submission as stated in the policies does not include the additional ninety (90) days allowed from the time proof is otherwise required.

Incomplete

- The reinstatement provision did not reflect that a premium accepted in connection with reinstatement may not be applied to any period more than sixty days prior to the date of reinstatement.

- The provision relating to legal actions was incomplete in policy GSP3. These two (2) policies did not clearly reflect that the stipulated time limit, in which no legal action may be brought to recover loss on the policies, is after "three years" from the time written proof of loss is required to be covered.

Policy GSP3 and SMXC did not reflect the required provision, (identified by caption), regarding "Change of beneficiary."

Page 16 of policy GSP3 and Page 7 of policy SMXC reflected:

> PROOFS OF LOSS: You must give Us written proof of loss to Our satisfaction within 90 days after the date of such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.

Pages 15 & 16 of policy GSP3 and Page 7 of policy SMXC reflected:

> REINSTATEMENT: If the renewal is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by Us without requiring an application for reinstatement will reinstate this policy. If We require an application, this policy will be reinstated when We approve the application, or on the 45th day after We receive it, unless We have previously written to You of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or a Sickness that manifests itself more than 10 days after such date. In all other respects, Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Page 16 of policy GSP3 reflected:

> LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after the expiration of the applicable statutes of limitations from the time written proof of the claim is required to be given.

Policies GSP1, GSP2 and CS1 did not reflect complete provisions required in individual policies in the following ways:

<u>Incomplete</u>

- The reinstatement provision did not reflect that a premium accepted in connection with reinstatement may not be applied to any period more than sixty days prior to the date of reinstatement.

- The policies did not reflect the required provision, (identified by caption), regarding "Change of Beneficiary."

Page 9 of policy GSP1, Policy GSP2 and page 11 of policy CS1 reflected:

> REINSTATEMENT: If the renewal is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by Us without requiring an application for reinstatement will reinstate this policy.
>
> If We require an application, this policy will be reinstated when We approve the application, or on the 45th day after We receive it, unless We have previously written to You of its disapproval.
>
> The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or a Sickness that manifests itself more than 10 days after

such date. In all other respects, Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Policies SHXC and HSXC-C did not reflect complete provisions required in individual policies in the following ways:

Incomplete

- The reinstatement provision did not reflect that a premium accepted in connection with reinstatement may not be applied to any period more than sixty days prior to the date of reinstatement.

- The policies did not reflect the required provision, (identified by caption), regarding "Change of Beneficiary."

Page 7 of policy SHXC and page 8 of policy HSXC-C reflected:

> REINSTATEMENT: If the renewal is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by Us (or by Our agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.
>
> If We or Our agent requires an application, this policy will be reinstated when We approve the application, or on the 45th day after We receive it, unless We have previously written You of its disapproval.
>
> The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In all other respects, Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Policies CANLS-2, CILS, CAGR, CAXC, CIXC and UA-250 did not reflect complete provisions required in individual policies in the following ways:

Incomplete

- The reinstatement provision did not reflect that a premium accepted in connection with reinstatement may not be applied to any period more than sixty days prior to the date of reinstatement.

Page 3 (pages not numbered) of Policy CANLS-2, page 4 of policy CILS and page 5 of policy UA-250 reflect:

GENERAL PROVISIONS

> REINSTATEMENT: If the renewal is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by Us (or by Our agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.
>
> If We or Our agent requires an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the

approval date. Lacking such approval the policy will be reinstated on the 45th day after the date of the conditional receipt unless we have written you earlier of its disapproval.

(Policy UA-250) If We or Our agent requires an application, this policy will be reinstated when We approve the application, or on the 45th day after We receive it unless We have previously written You of its disapproval.

The reinstated policy will cover only First Diagnosis of Cancer [or of a Covered Critical Illness]that is manifested more than 10 days after the date of reinstatement. In all other respects, Your rights and Our rights will remain the same, subject to any provisions endorsed on or attached to the reinstated policy.

(Policy UA-250) The reinstated policy will cover only loss that results from an Injury sustained after the date of reinstatement. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Page 7 of policy CAGR policy, Page 3 of policy CAXC and Page 2 of policy CIXC reflected:

REINSTATEMENT: If the renewal is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by Us (or by Our agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If We or Our agent requires an application, this policy will be reinstated when We approve the application, or on the 45th day after We receive it unless We have previously written You of its disapproval.

The reinstated policy will cover only loss that results from [an Injury sustained after the date of reinstatement] or Sickness that starts more than 10 days after such date. In all other respects, Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Certificates TRHPC and ERHPC, Retiree Health Benefit Plans, did not reflect complete provisions required in large group policies in the following way:

- The certificates did not reflect any information concerning the method that is to be used for the adjustment of premiums and benefits when the age of the insured has been misstated.

Page 1 of Certificates TRHPC and ERHPC-CO reflected:

RENEWAL PROVISION

Until you are age 81, your premiums will be adjusted on each certificate anniversary solely because of your age change. Your premiums may also be adjusted due to unanticipated increasing health care costs for all certificates in your class.

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01
Cancer Policy (1st Diagnosis Benefit)	CANLS-2	Submitted: 10/10/05 Stamped: 12/05/05
Cancer Policy (Hospital Confinement)	CAGR	Submitted: 04/19/90 Stamped: 09/24/90
Cancer Policy (Expense & Indemnity)	CAXC	Submitted: 07/25/80 Stamped: 07/28/80
Cancer Policy (Indemnity)	CIXC	Submitted: 07/28/80 Stamped: 08/27/80
Critical Illness policy (1st Diagnosis Benefit) excluding Cancer	CILS	Submitted: 11/24/03 Stamped: 12/08/03
Teamsters Retiree Health Plan Certificate (Large Group)	TRHPC	Submitted: 08/14/96 Stamped: 08/22/96
Employer Retirement Health Plan Certificate (Large Group)	ERHPC-CO	Submitted: 07/08/97 Stamped: 07/17/97
Accident Expense Policy	UA-250	Submitted: 08/04/93 Stamped: 06/07/94

Recommendation No. 21:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-16-202 and 10-16-214, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect complete and correct provisions in its individual and group coverage plans as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant benefit provisions and the proposed date that the forms will be put in use.

Issue E20: Failure, in some instances, to reflect correctly or to reflect any benefits to be paid for the preventive health care service of colorectal cancer screening.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(18) Preventive health care services.

(a)(I) Except as specified in subparagraph (II) of this paragraph (a), *the following policies and contracts that are delivered, issued, renewed, or reinstated on or after July 1, 2009, shall provide coverage for the total cost of the preventive health care services specified in paragraph (b)of this subsection (18)*: [Emphasis added.]

(A) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article.

. . .

(III) *Coverage shall not be subject to policy deductibles. . . .* [Emphasis added.]

. . .

(b) The coverage required by this subsection (18) shall include coverage for the tests specified in subparagraph (II) of this paragraph (b) for the early detection of colorectal cancer and adenomatous polyps for those covered persons who are specified in subparagraph (I) of this paragraph (b):

(I) Asymptomatic, average risk adults who are fifty years of age or older and covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider;

(II) The following tests as determined by the provider that detect adenomatous polyps or colorectal cancer; Modalities that are currently included in an A recommendation or a B recommendation by the task force.

(c) For purposes of this subsection (18):

(I) "A recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

(A) Found good evidence that the preventive health care service improves important health outcomes; and

(B) Concluded that the benefits of the preventive health care service substantially outweigh its harms.

(II) "B" recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

(A) Found at least fair evidence that the preventive health care service improves important health outcomes; and

(B) Concluded that the benefits of the preventive health care service outweigh its harms.

(III) "Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal department of health and human services.

United policies GSP3, SMXC, CS1, GSP1, GSP2, SHXC, HSXC-C, MMXC, SSXC and retirement health benefit plan certificates, TRHPC and ERHPC-CO, were not in compliance with Colorado insurance law in that they failed to indicate coverage for the mandated preventive health care service of tests for early detection of colorectal cancer and adenomatous polyps. The requirement to provide this coverage was effective July 1, 2009 for policies and contracts delivered, issued, renewed, or reinstated.

The rider used with certificate GRGSP2C, (BRO81RC), used to provide a Colorectal Cancer Screening Benefit, was not correct as it reflected that the benefit is subject to any deductible which may appear in the attached policy or certificate. The benefit schedule in the certificate indicated that there is a deductible.

The Rider (1 page) reflected:

> We will pay the expense incurred for a colorectal cancer screening for any person covered under the attached policy or certificate, in accordance with the current American Cancer Society colorectal cancer screening guidelines.
>
> All benefits are subject to any copayment and coinsurance provisions of the attached policy or certificate. *This benefit is also subject to any deductible* or dollar limit provisions which may appear in the attached policy or certificate. [Emphasis added.]

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Surgical Medical Expense	SMXC	Submitted: 08/02/1983 Stamped: 08/05/1993
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
LB Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
LB Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73
Rider-Colorectal Cancer Screening Benefit	BRO81RC	
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.
Teamsters Retiree Health Plan Certificate (Large Group)	TRHPC	Submitted: 08/14/96 Stamped: 08/22/96
Employer Retirement Health Plan Certificate (Large Group)	ERHPC-CO	Submitted: 07/08/97 Stamped: 07/17/97

Recommendation No. 22:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect the mandated coverage to be provided for colorectal cancer screening as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant benefit provisions and the proposed date that the forms will be put in use.

Issue E21: Failure, in some instances, to reflect correct or any information concerning the mandated benefits and coverage provisions for diabetes.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(13) Diabetes.

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for diabetes that shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items pursuant to Colorado law, and, if coverage is provided through a managed care plan, such qualified provider shall be a participating provider in such managed care plan.

(b) Diabetes outpatient self-management training and education when prescribed shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

(c) The benefits provided in this subsection (13) are subject to the same annual deductibles or copayments established for all other covered benefits within a given policy.

United's policies HIXC, HMXC, CS1, GSP2, SHXC, HSXC-C, MMXC and retiree health benefit plan certificates TRHPC and ERHPC-CO were not in compliance with Colorado insurance law in that they did not reflect any information concerning the mandated benefits and coverage provisions for diabetes.

Form Name	Form Number	Date of Filing
Hospital Indemnity	HIXC	Resubmitted: 05/24/76 Stamped: 05/26/76
Hospital Indemnity	HMXC	Submitted: 09/14/79 Stamped: 09/18/79
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
Hospital & Surgical Expense	SHXC	Submitted: 09/29/87 Stamped: 10/05/87
Hospital & Surgical Expense	HSXC-C	Submitted: 10/18/83 Stamped: 11/01/83

Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.
Teamsters Retiree Health Plan Certificate (Large Group)	TRHPC	Submitted: 08/14/96 Stamped: 08/22/96
Employer Retirement Health Plan Certificate (Large Group)	ERHPC-CO	Submitted: 07/08/97 Stamped: 07/17/97

Recommendation No. 23:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect the mandated benefit coverage for diabetes coverage as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant benefit provision for diabetes and the proposed date that the forms will be put in use.

Issue E22: Failure, in some instances, to allow coverage for losses resulting from a covered person being under the influence of an intoxicant or a narcotic.

Section 10-16-201, C.R.S., Form and content of individual sickness and accident insurance policies, states in part:

> . . .
>
> (6) *An individual policy of sickness and accident insurance*, other than a long-term care policy, disability income policy, or supplemental policy covering a specified disease or other limited benefit, *issued, renewed, or reinstated on or after January 1, 2007, shall not contain any provision that limits or excludes payments under hospital or medical benefits coverage to or on behalf of the insured because the insured or a covered dependent sustained an injury while intoxicated or under the influence of a controlled substance*, as defined in section 18-18-102(5), C.R.S. [Emphasis added.]

United's policies GSP3, HIXC, HMXC, MMXC and SSXC were not in compliance with Colorado insurance law in that they excluded coverage for any loss resulting from a covered person being under the influence of an intoxicant or a narcotic.

Page 15 of policy GSP3 reflected:

> **LIMITATIONS AND EXCLUSIONS**
>
> . . .
>
> 15. Any care, treatment, services, or supplies for drug abuse or addiction, including alcoholism or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a Physician; *or any loss resulting from any Covered Person being under the influence of an intoxicant or a narcotic*; [Emphasis added.]

Page 3 (pages not numbered) of policy HIXC reflected:

> POLICY PROVISIONS
>
> INTOXICANTS AND NARCOTICS: The Company shall not be liable for any loss sustained or contracted in consequence of a Family Member's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Page 3 (pages not numbered) of policy HMXC reflected:

> POLICY PROVISIONS
>
> INTOXICANTS AND NARCOTICS: The Company shall not be liable for any loss sustained or contracted in consequence of a Family Member's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Page 3 (pages not numbered) of policy MMXC reflected:

PART 10 LIMITATIONS AND EXCLUSIONS

1. This policy does not cover pregnancy (including childbirth or complications arising therefrom except as provided in Part 8 *or any loss due to* functional nervous or mental disorder, rest cure, *alcoholism*, dental treatment, confinement to any institution where the Family Member is entitled to service without cost or any loss covered by any Workmen's Compensation or Employers Liability Law. [Emphases added.]

Page 3 (pages not numbered) of policy SSXC reflected:

Part 5 LIMITATIONS AND EXCLUSIONS

1. This policy does not cover childbirth, pregnancy or miscarriage, or complications arising therefrom except as provided in Part 2, *any loss due to* functional nervous or mental disorders, rest cures, *chronic alcoholism*, dental treatment, any disability while confined to any institution where any Family Member, is entitled to service without cost to himself or any loss covered by any Workmen's Compensation or Employers Liability Laws. [Emphases added.]

Form Name	Form Number	Date of Filing
Surgical Medical Expense	GSP3	Submitted: 08/18/2008 Stamped: 09/17/2008
Hospital Indemnity	HIXC	Resubmitted: 05/24/76 Stamped: 05/26/76
Hospital Indemnity	HMXC	Submitted: 09/14/79 Stamped: 09/18/79
LB Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
LB Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73

Recommendation No. 24:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-201, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date that this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to provide coverage for losses resulting from a covered person being under the influence of an intoxicant or a narcotic as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division

with specimen copies of all revised policy forms containing compliant coverage provisions and the date that the forms will be put in use.

Issue E23: Failure, in some instances, to provide credit for previous coverage for any conditions or for certain named conditions.

Section 10-16-102, C.R.S., Definitions, states in part:

. . .

(13.7) "Creditable coverage" means benefits or coverage provided under:

(a) Medicare, Medicaid, or the children's basic health plan established pursuant to article 8 of title 25.5, C.R.S.;

(b) An employee welfare benefit plan or group health insurance or health benefit plan;

(c) An individual health benefit plan;

(d) A state health benefits risk pool (including but not limited to CoverColorado); or

(e) Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5 (e) of the federal "Peace Corps Act" (22 U.S.C. Sec. 2504 (e)).

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

. . .

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. . . .

The United policies identified below were not in compliance with Colorado insurance law in that:

Policy HIXC excluded coverage for six (6) months for any loss resulting from cancer or hernia caused by accident or otherwise, or any loss which involves treatment, repair or removal of any of the generative organs.

Policy HMXC excluded coverage for <u>any</u> loss resulting from injury sustained or sickness first manifesting itself prior to the effective date of the policy for 120 days after the effective date of the policy.

Page 2 of policy HIXC (pages not numbered) reflected:

PART 8 LIMITATIONS AND EXCLUSIONS

. . .

2. Any loss resulting from cancer or hernia caused by accident or otherwise, or any loss which involves treatment, repair or removal of any of the generative organs shall be covered only if the loss occurs after this policy has been in force for 6 months.

Page 2 of policy HMXC (pages not numbered) reflected:

PART 3 LIMITATIONS AND EXCLUSIONS

. . .

4. Loss resulting from injury sustained or sickness first manifesting itself prior to the effective date of this policy is not covered unless incurred more than 120 days after the effective date.

Policies CS1, GSP1 and GSP2 were not in compliance with Colorado insurance law in that there was no allowance reflected for the possibility of creditable coverage reducing or eliminating the time period applicable for coverage to be available for a preexisting condition.

Page 3 of Policy CS1, Page 2 of Policy GSP1 and Policy GSP2 reflect:

PRE-EXISTING CONDITION LIMITATION

This policy does not insure You against loss incurred during the twelve (12) months immediately after the effective date of this policy if that loss results from a Pre-Existing Condition. In addition, any Pre-Existing Condition listed on the application is not covered for the first twelve (12) months after the policy effective date.

Policies MMXC and SSXC were not in compliance with Colorado insurance law in that they reflected a delay in providing coverage or benefits for certain conditions which would exclude giving credit for previous creditable coverage.

Page 3 (pages not numbered) of Policy MMXC reflected:

PART 10 LIMITATIONS AND EXCLUSIONS

. . .

2. Any loss resulting from cancer, hernia caused by accident or otherwise, or any loss which involves treatment, repair or removal of any of the generative organs shall be covered only if the loss occurs after this policy has been in force for 6 months.

Page 3 (pages not numbered) of policy SSXC reflected:

PART 5 LIMITATIONS AND EXCLUSIONS

. . .

2. Any loss resulting from cancer or hernia caused by accident or otherwise, or any loss which involves treatment, repair or removal of any of the generative organs shall be covered only if the loss occurs after this policy has been in force for 6 months.

Form Name	Form Number	Date of Filing
Hospital Indemnity	HIXC	Resubmitted: 05/24/76 Stamped: 05/26/76
Hospital Indemnity	HMXC	Submitted: 09/14/79 Stamped: 09/18/79
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Limited Hospital & Surgical Expense	GSP1	Submitted: 09/11/98 Stamped: 11/18/98
Limited Benefit Hosp & Surg Expense	GSP2	Submitted: 11/15/04 Stamped: 12/07/04
Hospital & Surgical Expense	MMXC	Submitted: 06/03/76 Stamped: 08/03/76
Surgical Expense	SSXC	Submitted: 07/17/73 Stamped: 07/23/73

Recommendation No. 25:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-16-102 and 10-16-118, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date of this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect the possibility of creditable coverage reducing or eliminating the time period applicable for coverage to be available for any preexisting conditions as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant language and the proposed date that the forms will be put in use.

Issue E24: Failure, in some instances, to reflect a correct definition of a pre-existing condition limitation.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, reflected in part:

(1) A health coverage plan that covers residents of this state:

(a)(I) *If it is a group health benefit plan*, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition *for losses incurred more than six months following the date of enrollment* of the individual in such plan or, *if earlier, the first day of the waiting period for such enrollment*; except that, for business groups of one, a health benefit plan shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the date of enrollment of the individual in such plan. A group health benefit plan may impose a preexisting condition exclusion or limitation only if such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, *for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment;* except that a group health benefit plan shall not impose any preexisting condition exclusion in the case of a child that is adopted or placed for adoption before attaining eighteen years of age, or relating to pregnancy. [Emphases added.]

(II) *If it is an individual health benefit plan*, or a group health coverage plan to which subparagraph (I) of this paragraph (a) does not apply, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage *and may not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within twelve months*. [Emphases added.]

United's policy CS1 reflected a definition of a pre-existing condition that was more restrictive than allowed by Colorado insurance law. A pre-existing condition is an injury, sickness, or pregnancy, for which a person incurred charges, received medical treatment, consulted a health care professional or took prescription drugs within the twelve months preceding the effective date of coverage.

Page 4 of policy CS1 reflected:

DEFINITIONS

PRE-EXISTING CONDITION means any condition for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the *24 month period immediately prior to the effective date of the Family Member's coverage under this policy.* It also means any condition for which the Family Member did receive treatment or medical advice *during the 24 month period*

> *immediately prior to the Family Member's effective date of coverage under this policy*. [Emphases added.]

The Certificate for policy GRGS2 was not in compliance with Colorado insurance law in that the definition of a "Pre-Existing Condition Limitation" that was reflected was incorrect. A group plan is not to deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than six (6) months following the date of enrollment or if earlier, the first day of the waiting period for such enrollment. The Certificate denied coverage for loss incurred during the twelve (12) months immediately after the effective date of the certificate for loss resulting from a pre-existing condition. Additionally the Certificate defined a pre-existing condition as one for which treatment or medical advice was received during the twelve (12) month period immediately prior to the effective date of coverage and a pre-existing condition exclusion is limited to medical advice, diagnosis, care, or treatment that was recommended or received within six (6) months immediately preceding the date of enrollment.

Page 2 of the Certificate reflected:

> **PRE-EXISTING CONDITION LIMITATION**
>
> This Certificate does not insure You against loss incurred during the [twelve (12)] months immediately after the effective date of this Certificate if that loss results from a Pre-Existing Condition. In addition, any Pre-Existing Condition listed on the application is not covered for the first [twelve (12)] months after the Certificate effective date.

Page 3 of the Certificate reflected:

> [**PRE-EXISTING CONDITION** means any condition for which symptoms existed which would cause a person to seek diagnosis, care or treatment within the [12] month period immediately prior to the effective date of You or the Family Member's coverage under this Certificate. It also means any condition for which the Family Member did receive treatment or medical advice during the [12] month period immediately prior to You or the Family Member's effective date of coverage under this Certificate.]

Form Name	Form Number	Date of Filing
Basic Hospital & Surgical Expense	CS1	Submitted: 11/01/91 Stamped: 11/29/91
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 26:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect a correct definition of a pre-existing condition limitation as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant pre-existing condition limitation provision and the proposed date that the forms will be put in use.

Issue E25: Failure to reflect correct or complete information in the certificate of Creditable Coverage used by the Company.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

. . .

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than *ninety days* prior to the effective date of the new coverage. . . . [Emphasis added.]

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S. states in part:

. . .

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances to ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.

Section 3. Applicability and Scope

This amended regulation shall apply to all certificates of creditable coverage issued on or after October 1, 2004.

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days.* For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days. [Emphasis added.]

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in the federal regulations incorporated below.

2. *Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.* [Emphasis added.]

. . .

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, *if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.* [Emphasis added.]

. . .

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. *However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation*. [Emphasis added.]

The Certificate of Creditable Coverage Form used by the Company reflected an incorrect number of sixty-three (63) instead of ninety (90) days to be allowed for a break in coverage for the purpose of giving credit for previous creditable coverage. Colorado law prevails over the federal regulations and indicates creditable coverage may be credited and certified if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Additionally the Creditable Coverage form did not reflect the definition of "significant break in coverage" that is required by Colorado insurance law.

The Certificate of Individual Health Insurance Coverage used by the Company reflected:

> IMPORTANT-This certificate provides evidence of your health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for medical conditions that you have before you enroll, if medical advice, diagnosis, care, or treatment is recommended or received for the condition during the 6-months before you enroll in the new plan. If you become covered under a group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to establish your right to buy coverage for yourself or your family, with no exclusion for previous medical conditions, if you are not covered under a group health plan.
>
> . . .
>
> 7. If all individual(s) identified in items 2 and 4 have at least 18 months of creditable coverage (disregarding periods of coverage *before a 63-day break*), mark an "X" here <x> and skip item 8 and 9. [Emphasis added.]

Form Name	Form Number
Certificate of Individual Health Insurance Coverage	HIPA-C

Recommendation No. 27:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado Insurance Regulation 4-2-18. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised its Certificate of Creditable Coverage to reflect correct and complete information as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of the revised Certificate of Creditable Coverage containing compliant provisions and the proposed date that the forms will be put in use.

Issue E26: Failure, in some instances, to reflect any fraud warning or a fraud warning that is substantially the same required wording on applications for insurance.

Section 10-1-128, C.R.S., Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration, states in part:

. . .

(6)(a) Each insurance company shall provide on all printed applications for insurance, or on all insurance policies, or on all claim forms provided and required by an insurance company, or required by law, whether printed or electronically transmitted, *a statement, in conspicuous nature permanently affixed to the application*, insurance policy, or claim form *substantially the same as the following*: [Emphasis added.]

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

United indicated that it used the Company's applications to provide the "Fraud Warning" required by Colorado insurance law. However, this fraud statement was not substantially the same statement wording or was not displayed at all on the following applications that were furnished by the Company as being in use or available for use during the examination period.

Not Substantially the Same

Form Number	Filed Date
LCGP(05) & LCGP(05)-ODF Health Application and Optional Dependents Form	01/10/07
MGAPB & MGAPB-ODF Health Application and Optional Dependents Form	No filing information provided
MGAPG & MGAPG-ODF Health Application and Optional Dependents Form	No filing information provided

Page 4 of Application LCGP, Application MGAPB and Application MGAPG reflect:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

No Fraud Statement Displayed

Form Number	Filed Date
GSP-AP Hospital Policy Application	No filing information provided
CILS-AR(05) Critical Illness Policy Application	No filing information provided
UC-AP Health Application	06/11/91
MA4 Accident and Health Application	09/23/86
CA-1 Cancer Policy Application	08/04/86
HA-7 (05) Basic Hospital Expense Policy Application	No filing information provided
HA-1 Application For Insurance	Submitted: 09/29/87 with Policy SHXC Filing letter states the application was approved 09/03/87
GRHAP Hospital and Surgical Expense Large Group Retiree Health Certificate Application-Used for Certificate GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05 Never filed in Colorado
TGRUA Teamsters Retiree Health Plan Certificate (Large Group) Application-Used for Certificate TRHPC	Submitted: 08/14/96 Stamped: 08/22/96
EGRUAP-CO Employer Retirement Health Plan Certificate (Large Group) Application-Used for Certificate ERHPC-CO	Submitted: 07/08/97 Stamped: 07/17/97

Recommendation No. 28:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-1-128, C.R.S. In the event that United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide evidence to the Division that it has revised all applicable forms to reflect a “fraud warning” with

substantially the same wording as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised forms containing compliant fraud warming notice and the proposed date that the forms will be put in use.

Issue E27: Failure to file a large group health policy marketed in Colorado during the period under examination.

Section 10-3-903, C.R.S., Definition of transacting insurance business, states in part:

. . .

(2) *The provisions of this section do not apply to*:

. . .

(h) Transactions in this state involving group sickness and accident or blanket sickness and accident insurance where the master policy was lawfully issued and delivered to a single employer in another state in which the company was authorized to do an insurance business, *when a master policy which covers residents of this state includes mammography benefits at a level at least as comprehensive as those required by section 10-16-104 (4);* [Emphases added.]

Section 10-16-107.2, C.R.S., Filing of health policies, states in part:

(1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall *submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado*. Such listing shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner. [Emphasis added.]

(2)(a) All sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities providing health care coverage authorized by the commissioner to conduct business in Colorado *shall also submit to the commissioner a list of any new* policy form, application, endorsement, or *rider at least thirty-one days before using such* policy form, application, endorsement, or *rider* for any health coverage. Such listing shall also contain a certification by an officer of the organization that each new policy form, application, endorsement, or rider proposed to be used complies, to the best of the insurer's good faith knowledge and belief, with Colorado law. The necessary elements of the certification shall be determined by the commissioner. [Emphases added.]

Colorado Insurance Regulation 1-1-6, Concerning The Elements Of Certification For Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-

Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", promulgated under the authority of §§ 10-1-109, 10-4-419, 10-4-633, 10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states in part:

. . .

Section 4. Definitions

For the purposes of this regulation:

. . .

D. "Annual Report for health coverage" shall mean a list of all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms.

. . .

M. "Listing of New Policy Forms for health coverage" shall mean a list of any new policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements *and riders* for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado and the title of the program or product affected by the form, *and the effective date the form will be used*. [Emphases added.]

Section 5. Rules

A. *At least 31 days prior to using any new form* (except preneed funeral contract and excess loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act" forms, which are filed concurrently) *each entity, subject to the provisions of this regulation, shall file, in a format prescribed by the Commissioner, a Listing of New Policy Forms including a fully-executed certificate of compliance.* Any such listing and the applicable certificate of compliance must be prepared individually for each product. [Emphases added.]

. . .

C. Not later than December 31 of each year, each entity providing health care coverages shall file an Annual Report of policy forms including a fully executed certificate of compliance. . . .

United was not in compliance with Colorado insurance law in that the following large group policy, in use in Colorado during the period under examination, was filed only in the District of Columbia. Section

10-3-903(2)(h), C.R.S., only allows group sickness and accident policies that were lawfully issued and delivered in another state to be exempt from transacting the business of insurance in Colorado when the master policy includes mammography benefits at a level at least as comprehensive as those required by § 10-16-104(4), C.R.S.

Form Name	Form Number	Date of Filing
International Brotherhood of Teamsters (Limited Benefit Hospital and Expense Plan)	GRGSP2C	Filed in the District of Columbia on 05/25/05 Stamped date: 06/29/05

Recommendation No. 29:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-16-104 and 10-16-107.2, C.R.S. and Colorado Insurance Regulation 1-1-6. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation that it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has implemented procedures to ensure that all policies marketed in Colorado are filed as required by Colorado insurance law.

Issue E28: Failure, in some instances, to allow expenses incurred due to an accident while participating in any hazardous sports or hazardous occupations.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> . . .
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> . . .
>
> (XVI) Excluding medical benefits under health care coverage subject to article 16 of this title to any covered individual based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off-highway vehicle riding; skiing; or snowboarding;

United's certificate for policy GRGSP2 was not in compliance with Colorado insurance law in that it reflected an exclusion that was overly broad and violated unfair claim settlement practices.

Page 8 of the Certificate reflected:

> **PART 9 LIMITATIONS AND EXCLUSIONS**
>
> . . .
>
> 13. Any expenses incurred due to an accident while participating in any hazardous sports or hazardous occupations.

Form Name	Form Number	Date of Filing
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 30:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation § 10-3-1104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission and rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised applicable forms to remove overly broad exclusions related to accident benefits for participating in hazardous sports and hazardous occupations in accordance with Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised forms containing compliant provisions and the proposed date that the forms will be put into use.

Issue E29: Failure, in some instances, to offer coverage for treatment of alcoholism that was at least equal to minimum requirements.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> . . .
>
> (9) Availability of coverage for alcoholism.
>
> (a) Any other provision of law to the contrary notwithstanding, no hospitalization or medical benefits contract *on a group basis* issued by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 of this article shall be sold in this state unless the policyholder under such contract or persons holding the master contract under such contract are offered the opportunity to purchase coverage for benefits for the treatment of and for conditions arising from alcoholism, *which benefits are at least equal to the following minimum requirements*. [Emphases added.]
>
> (I) In the case of benefits based upon confinement as an inpatient in an accredited or licensed hospital or in any other public or private facility or portion thereof providing services especially for the treatment of alcoholics, which is licensed by the department of human services for those services, such benefits shall be not less than forty-five days in any calendar year.

United's rider BRO82SA, used with policy certificate GRGSP2C, was not in compliance with Colorado insurance law in that it did not meet the requirement of reflecting benefits for treatment of and for conditions arising from alcoholism that are at least equal to minimum requirements in the following way:

- Inpatient benefit days of twenty-eight (28) per year for inpatient or residential care in a hospital or nonhospital residential facility was reflected. Even when combining these days with those reflected for what appear to be for "detoxification", (12 days annually) a total of only forty (40) days is produced. The minimum requirements for inpatient benefit days are not to be less than forty-five days in any calendar year.

Page 2 of rider BRO82SA reflected:

> ALCOHOLISM AND DRUG DEPENDENCY BENEFITS
>
> . . .
>
> 2. The process whereby a covered person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body. This process is limited to 12 days annually.
>
> 3. Additional treatment as a covered benefit shall be provided by a hospital, Nonhospital Residential Facility, an Outpatient Treatment Facility, a physician, a psychologist, an advanced practice registered nurse, or a social

worker and shall include Inpatient Services, Outpatient Services, or any combination these, (sic), certificated (sic) as Medically Necessary by a physician, psychologist, advanced registered nurse, or social worker. This treatment is limited to 28 days per year for inpatient or residential care in a hospital or Nonhospital Residential Facility, and for a minimum of 30 outpatient visits per year.

Form Name	Form Number	Date of Filing
Rider: Definitions	BRO82SA	
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05. Never filed in Colorado.

Recommendation No. 31:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to provide such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date that this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect benefits for treatment of and for conditions arising from alcoholism that are at least equal to minimum requirements as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant benefit provisions and the proposed date that the form will be put in use.

Issue E30: Failure, in some instances, to provide benefits for biologically based mental illness and mental disorders.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(5.5) Biologically based mental illness and mental disorders.

(a)(I) Every group policy, plan certificate, and contract of a carrier subject to the provisions of part 2, 3, or 4 of this article, except those described in section 10-16-102 (21) (b), *shall provide coverage for the treatment of biologically based mental illness that is no less extensive than the coverage provided for a physical illness*. [Emphasis added.]

(II) Every group policy, plan certificate, and contract of a carrier subject to the provisions of part 2, 3, or 4 of this article, except a small group plan, as defined in section 10-16-102 (42), and a policy or plan as described in section 10-16-102 (21) (b), *shall provide coverage for the treatment of mental disorders that is no less extensive than the coverage provided for a physical illness*. [Emphasis added.]

. . .

(IV) As used in this subsection (5.5):

(A) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

(B) "Mental disorder" means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. The term includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient, day treatment, and in-patient basis, exclusive of residential treatment.

The certificate used with United's policy GRGSP2 was not in compliance with Colorado insurance law as it excluded benefits for nervous or mental disorders.

Page 8 of certificate GRGSP2C reflected:

PART 9 LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this Certificate for:

. . .

3. Convalescent, skilled nursing, educational care or for nervous or mental disorders;

Additionally, rider BR082SA, filed for use with Policy GRGSP2 and providing substance abuse and mental illness coverage was used as a benefit that may be elected or not elected. The biologically based mental illness and mental disorder benefit is not an optional benefit, but a mandated benefit for group plans, except a small group plan, as defined in § 10-16-102 (42), C.R.S. and a policy or plan as described in § 10-16-102 (21) (b), C.R.S. The Rider did not reflect benefits that correlate with being no less extensive than the coverage provided for a physical illness as is required by Colorado insurance law in the following ways:

- The policy reflected benefit payments at the rate of 80% for expenses incurred for outpatient services. The Rider reflected a minimum rate of 75% for the first 40 outpatient visits per year and a minimum rate of 60% for any outpatient visits thereafter for that year.

Page 2 of the Rider reflected:

MENTAL ILLNESS BENEFITS

. . .

2. Treatment under this section shall be limited to 45 days per year for inpatient or residential care in a hospital or Nonhospital Residential Facility and at a minimum rate of 75% for the first 40 outpatient visits per year and at a minimum rate of 60% for any outpatient visits thereafter for that year.

United's certificates TRHPC and ERHPC, Retiree Health Benefit Plans, were not in compliance with Colorado insurance law as nothing was reflected to indicate coverage is to be provided for treatment of biologically based mental illness and for the treatment of mental disorders.

Form Name	Form Number	Date of Filing
Rider: Definitions	BR082SA	
Hospital and Surgical Expense Large Group Retiree Health Certificate	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05 Never filed in Colorado
Teamsters Retiree Health Plan Certificate (Large Group)	TRHPC	Submitted: 08/14/96 Stamped: 08/22/96
Employer Retirement Health Plan Certificate (Large Group)	ERHPC-CO	Submitted: 07/08/97 Stamped: 07/17/97

Recommendation No. 32:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event United is unable to show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect the coverage to be provided for biologically based mental illness and mental disorders as required by Colorado insurance law. Within these sixty (60) days, United shall also provide the Division with specimen copies of all revised policy forms containing compliant benefit provisions and the proposed date that the forms will be put in use.

RATES

Issue F1: Failure to file and use of unfiled rates.

Section 10-16-107, C.R.S., Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain, states in part:

> (1) Rates for any sickness, accident, or health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, enrollee, subscriber, or member in Colorado, by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 or 4 of this article shall not be excessive, inadequate, or unfairly discriminatory. To assure compliance with the requirements of this section that rates are not excessive in relation to benefits, *the commissioner shall promulgate rules to require rate filings* and, as part thereof, may require the submission of adequate documentation and supporting information including actuarial opinions or certifications and set expected benefits ratios. [Emphasis added.] . . .
>
> . . .
>
> (2) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, *until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner*. [Emphasis added.]

Colorado Insurance Regulation 4-2-11, Rate Filing and Annual Report Submissions Health Insurance, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-107(1), 10-16-107(1.5), 10-16-109, and 10-18-105(2), C.R.S., (effective January 1, 2009) states in part:

> . . .
>
> Section 4 Definitions
>
> . . .
>
> F. *"File and use"* is a filing procedure that *requires rates and rating data to be filed with the Division of Insurance concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates*. [Emphasis added.]

Colorado Insurance Regulation 4-2-11, Rate Filing and Annual Report Submissions Health Insurance, promulgated under the authority of §§ 10-1-109, 10-3-1110, 10-16-107(1), 10-16-107(1.5), 10-16-109, and 10-18-105(2), C.R.S., (effective July 1, 2009) states in part:

> . . .

Section 4 Definitions

. . .

F. *"File and use"* is a filing procedure that *requires rates and rating data to be filed with the Division of Insurance concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstances shall the carrier use the rates for the collection of premiums until after the proposed effective date specified in the rate filing* [Emphasis added.]

United was not in compliance with Colorado insurance law in that it had not filed rates for three group retiree health plans which have been in use in some cases as early as 1996, and continued to be offered during the examination period.

In response to a request from Division for copies of all rate filings pertaining to the Company's group retiree health plans, the Company responded that they consider these plans to be exempt from the Medicare Supplement rate filing rules, and therefore no rates have been filed. The Company has also indicated in previous correspondence with the Division that rates were not filed for these products since the benefit packages were experience rated and would be fully negotiated with each group sponsor. However, the Company had been previously informed by the Division, that Group Retiree Medical policies are not Medicare Supplement policies, and must therefore comply with health laws for group policies, including § 10-16-107, C.R.S., and Colorado Insurance Regulation 4-2-11.

All carriers doing business in Colorado are required to file rates prior to marketing a product and these three (3) plans do not appear to be exempt from these requirements.

Form Name	Form Number	Date of Filing
Hospital and Surgical Expense Retiree Health Plan Certificate (Large Group)	GRGSP2C	Filed with the District of Columbia Department of Insurance 05/25/05 Never filed in Colorado
Teamsters Retiree Health Plan Certificate (Large Group)	TRHPC	Submitted: 08/14/96 Stamped: 08/22/96
Employer Retirement Health Plan Certificate (Large Group)	ERHPC-CO	Submitted: 07/08/97 Stamped: 07/17/97

Recommendation No. 33:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submittal or rebuttal as to why it should not be considered in violation of § 10-16-107, C.R.S. and Colorado Insurance Regulation 4-2-11. In the event the Company is unable to show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to ensure that all rates are filed prior to marketing a product as required by Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances to pay, deny or settle claims within the required time periods.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

. . .

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

. . .

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and *within forty-five calendar days after receipt by the carrier if submitted by any other means.*

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) *shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

The examiners identified ninety-two (92) claims from the total population of 9,327 claims received during the examination period that required more than forty-five (45) calendar days from date of receipt to process. Three (3) claims were listed twice, which reduced the number to eighty-nine (89). United was not in compliance with Colorado insurance law in that seventy-eight (78) of the eighty-nine (89) claims were determined to be clean claims that were not paid, denied or settled within the required forty-five (45) days.

NON-ELECTRONIC CLAIMS ADJUDICATED 45 DAYS OR MORE AFTER RECEIPT

Population	Sample Size	Number of Exceptions	Percentage to Sample
89*	89	78	88%

*.9% of all non-electronic claims received

The examiners identified twenty-three (23) claims from the total population of 9,237 claims received during the examination period that required more than ninety (90) calendar days from date of receipt to process. One of these claims was listed twice, which reduced the number to twenty-two (22). United was not in compliance with Colorado insurance law in that none of the twenty-two (22) claims that were not paid, denied or settled within the required ninety (90) days for claims not involved fraud.

CLAIMS ADJUDICATED 90 DAYS OR MORE AFTER RECEIPT

Population	Sample Size	Number of Exceptions	Percentage to Sample
22*	22	22	100%

*.2% of all claims received

Recommendation No. 34:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event United is unable to show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing that it is in compliance.

Otherwise, United shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied or settled within the required time periods in compliance with Colorado insurance law.

Issue J2: Failure, in some instances, to pay late payment interest and/or penalties due on claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> . . .
>
> (4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically *and within forty-five calendar days after receipt by the carrier if submitted by any other means*.
>
> . . .
>
> (c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.
>
> (5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit *and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the clam, accruing from the date payment was due pursuant to subsection (4) of this section*.
>
> (b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim*. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier. If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant a civil action in accordance with section 10-3-1116, the carrier shall pay the penalty in this paragraph (b) to the insured or to the assignee. [Emphases added.]

United was not in compliance with Colorado insurance law in that, in some instances, it did not pay the late payment interest and/or penalties that were due on claims not paid, denied or settled within the required time periods.

During the review of claims, the examiners determined that if the amount of interest due on a claim was under $1.00, the Company considered it “de minimus” and did not pay it. There is no exception in Colorado insurance law for not paying late payment interest on benefits based on the amount of interest due. The examiners identified twenty-two (22) instances in which late payment interest was owed, but had not been paid.

Once this issue was brought to the Company’s attention, the Company chose to issue late payment interest checks during the examination and the examiners were furnished with documentation of the payments.

PAID CLAIMS ADJUDICATED BEYOND 45 DAYS FOR WHICH INTEREST WAS OWED BUT NOT PAID

Population	Sample Size	Number of Exceptions	Percentage to Sample
39*	39	22	56%

*.8% of all paid claims

The examiners also determined that in some instances, United had not paid the required penalty on claims not paid, denied or settled within ninety days (90) after receiving the claim. The examiners determined eleven (11) of the twenty-two (22) claims not paid, denied or settled within ninety (90) days did not include the required twenty percent (20%) penalty with the payment. As with the unpaid interest payments, once this issue was brought to the United's attention, the Company chose to pay the applicable penalty amounts owed during the examination and provided the examiners with documentation of the payments.

PAID CLAIMS ADJUDICATED BEYOND 90 DAYS FOR WHICH-NO PENALTY WAS PAID

Population	Sample Size	Number of Exceptions	Percentage to Sample
22*	22	11	50%

*.1% of all claims received

Recommendation No. 35:

United shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event United is unable to show such documentation, the Company may submit, with its submission or rebuttal, its plan to comply, or documentation showing it is in compliance.

Otherwise, United shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has established the necessary procedures to ensure that all late payment interest and penalties due on claims is paid, regardless of the amount, in compliance with Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

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penalties due on claims.		

Examination Report Submission

State Market Conduct Examiner

Jeffory A. Olson, CIE, MCM, FLMI, AIRC, ALHC

And

Independent Contract Examiners

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP, MCM, PHIAS

And

Lynn L. Zukus, AIE, FLMI

Submit this report on this 24th Day of February, 2012 to:

The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202